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SURGEON'S VADE MECUM:

A MANUAL

OF

MODERN SURGERY.

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BY

ROBERT DRUITT.

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TO

CHARLES MAYO, ESQ.,

SENIOR SURGEON TO THE HAMPSHIRE COUNTY HOSPITAL AT WINCHESTER,

IN ADMIRATION OF HIS SOUND JUDGMENT AND SKILL IN SURGERY,

AND

IN GRATEFUL ACKNOWLEDGMENT OF EARLY KINDNESS,

THIS WORK

IS DEDICATED BY HIS AFFECTIONATE NEPHEW

AND OBEDIENT SERVANT,

ROBERT DRUITT.

37 HERTFORD STREET, MAYFAIR, LONDON, W.
11th March, 1865.

PREFACE.

I AM extremely sorry that this Ninth Edition has been long delayed, to the great inconvenience of the Publishers, as well as of numerous professional friends and students in all parts of the world, who have frequently, and in vain, asked for it through their booksellers. All I can say in explanation is, that I never before was so painfully conscious both of the labour and of the responsibility incurred in editing such a book. It is not like any literary work, edition after edition of which, when once complete, merely requires common care in reprinting. On the contrary, in dealing with a constantly shifting and enlarging body of knowledge, such as any branch of medicine, there is not a single fact, or hypothesis, or mode of practice, that does not require to be repeatedly weighed and examined and tested by the most modern researches.

I would that it were possible to give here even a bird's-eye view of the changes which have come over our profession in its ideas, theories, phrases, and rules of practice during the five-and-twenty years which have passed since the first edition of this book. How unfounded are the notions of those who believe that medicine is a conservative, a bigoted, or a stationary profession! I will attempt to point out a very few of them, although it would take a large volume to tell even of these fully. In doing so, I shall follow the order of my own book, and shall take the opportunity of mentioning some of the changes which have been made in this edition.

Of the First Part, which treats very shortly of certain nervous affections accompanying local disease or injury, there is little to be said. The phenomena of "shock" appear now

Disease and Repair, and of that whic
wrongly, considered the scientific basis o
and surgery, considerable changes have be

During the years 1834–1840 in which
schools, the great modern microscopic
structure and development and changes
in the embryo, or in growth, or in diseas
ning to be known to professors. At that ti
doctrines dominant amongst the great bo
who had taken their tone from the teac
generation, were *dynamic;* that is, they
forces, dispositions, and sympathies, sup
the animal body, with very little heed to *qu*
position. During those years the Scottish s
by Cullen and John Hunter, still held its pe
medical teaching and practice. Because t
ancient humoral pathology were fanciful (ho
been otherwise when chemistry was unknow
the chemistry of his time was too imperfect to
of the blood in disease, Cullen contemptuously
of the *composition* of the animal body as wo
work to speculate on its *actions*. Hunter'
based on abstract ideas of action and power,
quantity or composition of that which acted.
to the fact that many actions must go on in
and blood-vessels are formed, physiologist

tion, being elaborated in the capillaries, and exuded from them" (for all secretions were then supposed to be formed in and by the capillaries, and to issue somehow from invisible exhalant orifices), but likewise that it might be formed in tissues and exudations outside the blood-vessels. I use the word apologetic purposely, because an eminent teacher of surgery with whom I was then familiar reproached me almost as if it were a personal offence to suppose that any "actions" could be done except by the capillaries, just as he considered me also a blind heretic for doubting the doctrine of John Hunter, that ulcers were eaten out by the "mouths of the absorbents."

At that day the microscopical observers of most authority described what they believed to be the conversion of blood globules into pus globules within the capillaries. They believed that they saw them enlarging in size and losing their colour, and afterwards exuding as pus from the surface of a sore. At that day, too, the student would have been asked "How do cartilages ulcerate?" and he would have been required to answer, "By the agency of the absorbents." And if asked presently, "How can we prove the existence of absorbents (lymphatics) in cartilage?" he would have been expected to reply, "Because they are liable to ulceration."

Does the student smile at this as a proof of the blindness of our fathers? He may smile; but he had better learn humbly that this is but a specimen of the vices inherent in the human mind, from which neither ours nor any age can be free. Vice the first is false observation—observation made with imperfect instruments, or distorted by preconceived ideas in the observer's mind. Vice the second is that kind of argumentation, in which what ought to be proved is taken for granted. This is the same now as ever, and is only to be counteracted by a wholesome scepticism, which shall be perpetually probing and testing those doctrines and practices which are most firmly held and implicitly acted on.

Another peculiarity of the pathology of that day illustrates a third vice of the human mind, which the student must be on his guard against now as ever. It is that of putting a moral colour on material facts, of allowing the "subjective" to intrude upon the "objective," and supposing the figures of our imagination to exist in reality. For example. The earliest microscopic observers, who set to work to explore the phenomena of inflammation in the transparent parts of

animals, naturally enough set themselves to see what was then considered the very *arcanum*, the *ne plus ultra* of vital action, namely, the condition of the blood-vessels. Expecting to find these in a state of "increased action," and expecting that the increased action of a blood-vessel should be an increased current of blood, they were surprised to see in the focus of an inflamed part, vessels distended, and blood motionless. They might have accepted this fact *simpliciter*. They might have said, Here are blood-vessels distended, possibly as a consequence or accompaniment of some coexisting condition; just as a "block" of carriages in the street may arise from "too languid a circulation," as when some carriage can't go fast enough;—or from *error loci*, as when a man insists on breaking the line;—or from "constriction," as when "a street is up;"—or from "increased attraction" of certain houses for carriages, as when a ball is given;—or from universal "plethora," as at a Lord Mayor's show. A stagnation of blood in the vessels of an inflamed part is no more a warrant for an absolute hypothesis as to its cause than a stoppage in the streets; yet our predecessors, the first microscopic pathologists, greedily seized this fact as a foundation for a theory that inflammation was a "debility" of the capillaries—a "debility," they thought, that must be counteracted by "stimulation;" for "debility," a term expressing a conception of the human mind, and "stimulation," a mere metaphor, were taken as the names of absolute existences antagonistic to each other.

To the error of assuming our mental conceptions to exist in external objects was superadded a fourth error, that of searching for "final causes." Any one who conceived any use to arise from any change in the animal economy, believed himself to have entered into the very counsels of the Deity, and to detect His purposes. The "symptomatic fever" which accompanies (and, as the ancients knew, *precedes*) many local inflammations was conceived to be a beneficent consequence. A fantastic goddess was set up called "Nature." She was supposed to live in and rule the animal body, to feel all its injuries and resent them. If a man shivered at the beginning of an illness, "Nature" felt an injury, and withdrew her forces from the extremities into the citadel of life. If he became feverish, if the whole heart and arteries throbbed tumultuously, it was Nature's mode of resisting an enemy; for it was really supposed that a "local debility" of the capillaries might excite the whole blood-vessels to furious "action" in order to overcome the obstruction; just as if a man should

burn down his house because one of his attic chimneys smoked. Unluckily for the "final cause," the preternatural action of the heart and arteries, instead of removing the difficulty it was supposed to be intended to remove, did but superadd a worse evil, and had to be repressed, in its turn, by antiphlogistics.

To these four cardinal errors, viz. imperfect observation, wrong argumentation, abuse of the subjective, in the ascribing a moral purpose or "intention," or "disposition" to matter, and belief in final causes, we add a fifth, which was abundantly illustrated by the example of our fathers. It is Rationalisticism—the error of neglecting common-sense humble observation, and of trusting to *à-priori* argument, in matters to which that line of argument is quite inapplicable. It differs from what is "rational," as a ghost differs from flesh and blood. It is a mere semblance of reasoning, grotesquely applied to a subject that does not admit of it. It is the same now, and ever will be, so long as we fondly believe that our pathological principles are established like mathematical truths, and that we are safe in deducing rules of practice from them, even though experience may go against us. This is well illustrated by the history of that abuse of blood-letting, which, if I read our professional history aright, prevailed, not with the ancients, not with the Sydenhams, not with the great English physicians of the eighteenth century, but in the days from about 1790 to 1840, during which our fathers fondly persuaded themselves that they acted upon the "scientific principles" laid down by the immortal John Hunter.

The hypothesis being that inflammation was an "action" of the vessels (for they that believed in "debility" of the inflamed capillaries believed in "action" of the larger vessels), and the further hypothesis being accepted, that the action of the vessels was kept up by distension from within, it *stood to reason* that the way to diminish action was to empty the blood-vessels. Alas! that so many things which stand to reason (such as it is) should not stand to fact. But as it was a logical deduction from established "principles," that bleeding must diminish action, so practitioners went on bleeding in inflammation, consoling themselves for the deaths of their patients by the reflection that they had done their duty. That blood-letting in certain cases of the early stage of inflammation is of enormous service is an ancient and indisputable fact. There are many theories on which its good effects can be explained, amongst which may be mentioned that of Dr. Markham, that it is beneficial chiefly in inflammations

which affect the act of respiration, and acts by diminishing the quantity of blood that need circulate in the lungs. But there is a fact I mention in these pages, which has been little noticed, and which may account for the perseverance with which blood was drawn in maladies where blood should rather have been injected—this is, the delicious sense of languor and ease which follows the abstraction of blood, as it does the Turkish bath. This delusive benefit was probably the real excuse for a custom which was kept up in compliance with the so-called "scientific principles" of that day, although if practitioners had calmly looked at results, they would have doubted their principles. Whoever will take the trouble to look at "Butter on Irritative Fever," will see the depleting practice of 1824 in its climax. He will see the fallacy of the theory which ascribes the discontinuance of bleeding wholly to "change of type" of disease. For patients were then bled repeatedly for a disease of a low, gangrenous type, in which we now, like the great practitioners of an earlier generation, should give bark and wine. Bleeding was then done to excess because our fathers had let themselves be led captive by the plausible "scientific principles" of Cullen and Hunter; and bleeding is not carried to excess now, because homely observation has shown those principles to be but partially true.

Whilst I thus unsparingly exhibit what I believe to be the errors of our fathers, I do so because they are in essence our own too. The vices of the human mind remain, though their manifestations may vary. The worst error of all is that of imagining that our predecessors were all wrong, and ourselves all right. If my reader will have the goodness to refer to what I say at p. 36, he will see grounds for humility. New medical theories ought to include the old, and not to upset them. Our fathers' theories (say that of "action of vessels") were partial glimpses—or glimpses at one aspect of an enormous subject. Ours are glimpses at another, perhaps a more advanced prospect. But it does not follow that because their theories did not include so many phenomena as ours, that they were wholly wrong or useless, or that their practice was all bad. I have ventured to denounce Hunter's theories, but I have the profoundest veneration for him as an observer and a practitioner. In fact, I have the fullest faith in the ART OF HEALING as practised by men of sense and sagacity in all ages;—men strong enough to act on their own instincts of what was right, spite of the theories of the day, which, like

cobwebs, bind the weaker men only. And we may rely on it, that there will be as little finality and stability in our views as in those of any of our predecessors. The great thing to be desired is, that each generation should reverentially consider and adopt such of its predecessor's labours as stand the test of experience instead of sweeping them contemptuously away and endeavouring to substitute an opposite and antagonistic universal theory. We need not be mere cellular pathologists, any more than mere vasculomotor pathologists, or humoralists. Each of these doctrines has some foundation, but to apply any one of them universally, would be to bring back the darkest ages of physic.

But to return. To the mere idea of *action*, as taught by Hunter, there succeeded a revival of the ancient humoral principles, to diffuse which the learned Dr. Copland's Dictionary, and Dr. Ferguson's Essay on Puerperal Fever, largely contributed. During twenty years, 1842–1862, this humoral pathology reigned. Action was shown to be largely dependent on the composition and quantity of the acting matter. This humoral pathology was accepted by all the great teachers, and shed a wholesome light over practice. Whoever used means to purify, to enrich, or to improve the blood, acted on principles acknowledged in the earliest days of physic, and destined to last as long as humanity itself, because founded on the experience of every-day life. The modern use of the microscope, and the knowledge of life in the tissues, as distinct from vascular action, was first made popular by a modest Report of Mr. Paget's in 1842. That Report indicates, in my mind, the beginning of modern medicine. What a gap separates it from J. F. Palmer's admirable edition of Hunter, published in 1835! Goodsir's Anatomical and Pathological Observations, Redfern on Ulceration of Cartilage, Hughes Bennett on Inflammation, Toynbee on Non-Vascular Tissues, and Lionel Beale's Researches on Nutrition, and on the "germinal" and "formed" elements of the Tissues are all, as it were, steps to a kind of knowledge sure to bear good fruit. If there were a fault, in modern humoralism, it was that perhaps too much was still assigned to the blood in the genesis of disease, and too little to the tissues. Exudations were supposed to be pre-existing in the blood, and to be poured out into the tissues, and there to generate within themselves the elements of new cell-growth. The more modern "cellular pathology" would show, on the contrary, that "exudations" are the work of the existing cell elements of the tissues, fed perhaps by impure blood, or

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consideration of the chemical characters of yellow tubercle is a preposterous piece of rationalisticism.

In the Third Part, which treats of the effects of different kinds of injuries and causes of disease, may be recognized with pleasure the fruits of an increased knowledge of the vital properties of the tissues. More confidence is placed in the power of the tissues to recover if placed under the right conditions. The surgeon interferes less. This is evident in the Chapter on Gun-shot Wounds, where the experience of the American war is quoted, and shows a far greater proportion of recoveries from gun-shot fractures, with proper food and appliances, than was possible amongst the half-starved English soldiers in the Crimea. But in this Part it is the chapter on Syphilis which shows most alteration. I took particular pains in writing it. Making my mind, as far as possible, a *tabula rasa*, and endeavouring to forget all the doctrines which have succeeded one another during the last twenty-five years, I began at the beginning, and read Fracastorius, and Ambroise Paré, and Astruc, not omitting the chain of authors given by him, as well as the abstracts of old writers in Daniel Turner's *Aphrodisiacus;* then I carefully studied Benjamin Bell and John Hunter, Astley Cooper and Abernethy, Ricord and Acton, Diday, Hutchinson, Wilks, Henry Lee, Bumstead, and Marston, side by side with the cases presented to me in ordinary life. The result, imperfect as it is, I hope will give my readers a clear and useful, as it is a thoroughly well-laboured and impartial account of the various questions afloat concerning this great pest of incontinence. Here is, I believe, a great and substantial progress in Surgery.

The Fourth Part, which treats of injuries and diseases of the various tissues, organs, and regions, has been very much added to. New and simplified Fracture Apparatus is described. If British surgery thought it had attained finality anywhere, it was in the ligature for wounded arteries. Professor Simpson has given a lesson on this point, not unmixed with rebuke. The revival of the pre-Hunterian operation for aneurism, and the increasing application of that treatment of aneurism, external and internal, by pressure, which we owe to Bellingham, Carte, Tufnell, and other members of the Dublin School, are shortly alluded to. Acupressure, the wire compress, flexion for aneurism, and the cure of aortic aneurism by pressure, (pp. 333, 770,) are marks of solid progress. New and safer methods of tying varicose veins are detailed. The chapter on

the Eye has been revised by my accomplished friend, Mr. R. Taylor, who has added an account of the modern treatment of Glaucoma by Iridectomy.

No sign of improvement is more striking than the methods of exploring internal organs and cavities by eyesight, which have been applied to eye, ear, uterus, rectum, and larynx within this generation, and by which a precision of diagnosis as to material conditions is substituted for the conceptions of our predecessors. Truly, medicine is not only changing, but growing; and I look with satisfaction on its future. As civilization and wealth advance, the public will give increased employment to men of education and general professional acquirements, who devote their attention to the exploration of the physical condition of any important organ. How many a patient in the last generation would have been spared the leechings, blisterings, issues, salivation, alteratives, &c. &c., if the real physical condition of eye or larynx could have been accurately demonstrated. The chapter on the Ear owes much to the revision of my friend Mr. Hinton. Tooth-ache may seem a triviality to those who have never felt it; but in writing the account of it at p. 493, in which I described, as well as I could, what had been done to myself by my friend Mr. Tomes, I wish I could have adequately conveyed to my readers the grateful sense I entertain of the benefits derivable from modern dentistry in scientific hands. That common and dangerous infirmity, Hernia, has been more fully treated of, especially as regards the new and ingenious measures for effecting a radical cure, which were introduced into England by Mr. Spencer Wells, and have been elaborated by Mr. Wood. The account of ovariotomy, and the statistics thereof, have been brought down to the present period. Here I fear that I must, amongst other vices of the human mind incident to professors of medicine, caution the student against that mental state, compounded of indolence, narrowness, and self-esteem which leads men whose minds refuse to receive new impressions, to feel irritated at the innovations of more active men. The *laudatio temporis acti* may be the infirmity of a generous mind: the desire to rest satisfied with one's own knowledge, and to repress all who would go further, is intolerable meanness and selfishness. We all must go on learning till we die.

The sections devoted to the urinary organs, and especially to lithotrity, have been revised and enlarged, though I must confess that the last-named subject is still very meagrely treated. General principles are easily given, but it is impos-

sible to decant into these pages all the working details that are familiar to Charles Hawkins or Henry Thompson. The chapter on the Surgery of the Female Generative Organs is also confessedly imperfect, and contains such points only as belong to "General Surgery," without making it distinctly obstetrical. It had been my intention to have written a complete chapter on the examination, diagnosis, and treatment of diseases of those organs; but after encountering the drudgery of the foregoing 650 pages, I shrank from the labour. Besides, the additions judged necessary to the other parts of the book rendered it difficult to add much to this. The chapters on Chloroform and on Operative Surgery have also been revised and much added to.

I wish I could even barely count up the improvements in the operative parts of Surgery begun or perfected in the last twenty-five years:—such as the merciful sleep under chloroform contrasted with the groans of yore: the more finished style of operating, which, though London never wanted good operators, was greatly promoted by Liston and W. Fergusson: the new mode of division by the écraseur: lithotrity and ovariotomy, once sneered at, now perfected: the mechanical details worked out for the union of cleft palate and of vaginal fistulæ: the bolder treatment of diseased joints by incision, with excision to fall back upon, instead of amputation: the more summary modes of dealing with stricture: the whole treatment of deformities worked into a scientific system: and withal the causes of death after operations better understood and guarded against.

For many years past my practice has been confined to medicine and midwifery. I have therefore had the greatest part of this edition, as of former ones, and especially all parts that relate to pure or operative surgery, submitted to the revision of an accomplished hospital surgeon, so as to relieve myself from responsibility, and increase the confidence of my readers.

The great kindness with which former editions have been received has made me the more anxious that this should not fall behind its predecessors; yet I am painfully conscious of its imperfections—even of those which arise from the narrow limits in which I am obliged to write. Surgery can now be condensed within no small space, and at best this work can but pretend to be a series of memoranda, sufficient perhaps for most maladies which fall

I find that the collection of formulæ at t
work has been received with great favour, and
to them considerably. Many of them are orig
tions by masters of repute, and others are such
own practice. It were greatly to be wished th
for specifics be continued with vigour. We w
which shall do for the exudations or cell-growt
fibro-plastic tumours, carbuncle, and the like, w
iodide of potassium, and salts of ammonia do u
in some cases of inflammatory, rheumatic, sc
syphilitic deposits. Such remedies can never b
or argued out *à priori*, but can only be attained
that is, by observation and experiment; and I
not repeat to my readers that the true "science"
is based, not on *à priori* argument, but on th
practice.

R.

37, *Hertford Street, Mayfair, W.*
11*th March*, 1865.

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THE

SURGEON'S VADE MECUM.

PART I.

ON SOME AFFECTIONS OF THE NERVOUS SYSTEM WHICH MAY ACCOMPANY LOCAL DISEASE OR INJURY.

CHAPTER I.

PROSTRATION, OR COLLAPSE.

CERTAIN affections of the nervous system may be caused by, or may accompany, or follow, or complicate, various diseases and injuries.

But when we speak of affections of the nervous system, we do not speak of anything immaterial or psychical; for every pain, every disorder of motion, or of thought, depends, without doubt (so far as surgery is concerned), upon physical conditions, although we are not at present able to state what such conditions may be.

DEFINITION.—We shall begin by describing the state commonly known as *prostration*, or *collapse*, or *shock to the nervous system*; by which terms we signify that interruption of the powers and actions of life, which immediately follows any severe injury.

SYMPTOMS.—The usual symptoms are, that the patient lies cold, and half unconscious; with a feeble pulse and imperfect sighing respiration. If the symptoms are analysed, they will be found to be compounded, 1st. Of the effects of depression of the heart's action; including the symptoms commonly known by the term *syncope*; and 2nd. Of the effects of shock, or interruption to the functions of the brain and nervous system; and it will be found that these sets of symptoms are unequally combined in various cases. Thus, sometimes depression of the vascular system predominates, and the patient lies in a state of perfect syncope, with the pulse and respiration imperceptible. Sometimes the nervous system is chiefly affected, the patient being insensible, even though the heart's action is restored; or bewildered and incoherent, as though intoxicated; or even comatose, as though he had taken a nar-

cotic poison. Nausea and vomiting; hiccup; suppression of urine; and in children, convulsions, are also very frequent symptoms.

The *duration* of these symptoms is also extremely various. Sometimes they pass off very quickly; but they may remain even for forty-eight hours before reaction is thoroughly established, for the process of recovery from collapse is commonly called *reaction*. A very familiar illustration of *collapse* is afforded locally by any severe blow. Supposing, for instance, a sharp blow on the shin, the patient is unable to move his leg for some minutes. We do not know what the exact change is, but we cannot doubt that the blow produces some physical change in the nerves leading to the muscles. A blow on the head produces what is commonly called *concussion* or *stunning;* in which the functions of the brain are lost through physical injury, and those of the respiratory and cardiac nerves are also more or less affected. In like manner, after a fracture of the leg, a patient may be unable to make water. Women, too, after operations about the perinæum or anus are prone to abort if pregnant.

CAUSES.—Collapse may be caused by every variety of injury to which mind or body is liable;—great and sudden extremes of grief, or joy, or fear, or cold;—large doses of any corrosive or sedative poison, such as arsenic, or tobacco;—great loss of blood, and mechanical injuries. It is most important that the surgeon should know what injuries are most likely to be followed by fatal collapse, in order that he may have proper materials for giving his prognosis. They are:—

Injuries of organs that are necessary to life, as the stomach and brain, or that are intimately connected with the visceral system of nerves, as the testicle and eye; and it is well known that severe concussion of these organs may extinguish life instantaneously;—extensive injuries of any sort, especially of the skin and joints;—lacerated and gun-shot wounds;—extensive burns;—and injuries that cause very great *pain*. Severe pain, by itself, is capable of exhausting the vital powers. Lastly, Injuries occurring to the very aged; or to persons that are enfeebled by excess and intemperance, or by long-standing bodily disease, or mental depression; injuries, moreover, which produce a state of blood unfavourable for reparation, or which find the blood in that state. From this it will be learned that the slightest injury or surgical operation may prove fatal to persons who labour under chronic organic disease, especially of the kidneys; or who have been harassed by continued anxiety and despondency of mind; so that in almost any case a firm persuasion that recovery is impossible is almost sufficient to render it so.

TREATMENT.—Supposing a patient to have just received a severe injury, and that independently of hæmorrhage, or of any local injury, he is in such a state of faintness and depression as to render his life precarious, the indication is, to excite the heart and brain to a moderate and healthy reaction. The remedies are, stimulants, of which hot brandy and water (or Formula 27) is the best;—nourishment, such as beef-tea;—and warmth by means of blankets, or of heated bricks, or

bottles of hot water put under the axillæ and between the thighs. When warmth and circulation are restored, the surgeon will hold his hand, so that he may not run the risk of setting up fever, or of bringing on hæmorrhage from any internal organ that may have been injured. — *Vomiting* may be allayed by soda water with brandy, or by sucking ice; or an opiate enema (F. 101), or by a mustard poultice (F. 156) to the epigastrium.—*Hiccup* may be relieved by sp. ætheris comp.—*Convulsions, delirium,* and *coma,* are to be treated by ammonia, stimulants, and beef-tea, with application of cold to the head if hot and throbbing.

Finally, the old vulgar and mischievous habit of bleeding patients immediately after an injury, before they have recovered from a state of faintness and depression, needs only to be mentioned to be condemned.*

CHAPTER II.

DELIRIUM TRAUMATICUM.

The writer has seen three kinds of delirium quickly follow injuries, independently of the light-headedness which may occur during the feverish stage.

1.) One is of the nature of delirium tremens, and usually affects persons of middle age and intemperate habits.

The symptoms are those of *delirium tremens.* The tongue is moist and tremulous; there is a general tremor of the muscles; the skin is covered with perspiration; the patient is totally sleepless, irritable in his temper, answers questions in a snappish, or peevish, or incoherent manner; is often anxious to call himself perfectly well; and, as the malady increases, he becomes restless, impatient, and talkative; wishes perhaps to get out of bed, and attempts to injure his attendants, and soon becomes most furiously maniacal. In some cases, however, the delirium is of a milder cast; the patient is haunted with extravagant ideas and spectral illusions; or fancies himself busied in his ordinary avocations, and talks perpetually about them. The pulse is rapid, face flushed, breathing quick, and most signs of excitement without force.

TREATMENT.—The *treatment* is that of delirium tremens, and consists chiefly of quietude and nourishment, and, if the patient be feeble and an old drunkard, it will be advisable to allow him to choose his favourite liquor, and not to stint him in it.

"If in twelve hours, or earlier, after an injury," says Mr. Vincent, "the pulse does not indicate increased action, if it becomes fluttering and unequal, when the surface does not seem to evolve heat; when the countenance is listless, and the patient reports himself better than it might be expected; and particularly if he is not clear in his answer,

* See Travers on *Constitutional Irritation, and Hunter on the Blood,* chap. ii.

then the best of all stimuli, brandy, should be thrown in, and if there be delirium, opium." The opium may be given either in one full dose (such as gr. ii.—iii. of solid opium, or ♏ xl.—lx. of Battley's solution), or in repeated small doses (such as gr. $\frac{1}{4}$—$\frac{1}{2}$ every hour or two hours); the repeated small doses being, perhaps, best, if debility and restlessness are very great. Beef-tea and other nourishment should be given. Mental excitement is better allayed by one or two kind but firm attendants than by straps and strait-waistcoats. The head should be frequently bathed with tepid water, and the bowels be opened by mild aperients. If coma supervenes, counter-irritation by means of sinapisms or blisters to the scalp, feet, or calves of the legs, may be tried.*

(2.) The second form is the ordinary mania, of a mild cast. There are some persons of advanced life predisposed to insanity in whom the pain and excitement of any operation or injury, or even of any painful disease, are quite sufficient to upset the mental balance.

(3.) The third kind is the hysterical, of which more in Chapter IV.

CHAPTER III.

TETANUS.

SECTION I.—INTRODUCTORY.

DEFINITION.—Tetanus is a disease manifested by tonic or continuous spasm and rigidity of the muscles of voluntary motion.

DIVISION.—(1.) It is divided into the *idiopathic*, or that which arises from some disorder of the blood or nervous system without wound, and the *traumatic*, or that which is caused by a wound. (2.) It may be *acute* or *chronic*. (3.) It may be *general* or *partial;* and when partial it is mostly confined to the neck and jaws, constituting *trismus*, or locked jaw. (4.) It is called *opisthotonos*, when the body is curved backwards, as it most commonly is; *emprosthotonos*, when it is curved forward; and *pleurosthotonos*, when it is drawn to one side, this being the most uncommon. (5.) The *trismus infantum*, or *neonatorum*, which attacks children soon after birth, is usually made a distinct species. (6.) Tetanus may in its *type* be *intermittent*, when it is caused by marsh miasmata, as it may be occasionally, like almost every other nervous affection. (7.) Lastly, there is the *hysterical tetanus*, in which all the outward symptoms of tetanus are produced, as a consequence of an hysterical state of the system.

SECTION II.—ACUTE TETANUS.

SYMPTOMS.—The patient first complains of stiffness and pain of the neck and jaws, as from a cold; his voice is husky; it is difficult

* Copland's Dict. *Art.* Delirium; Graves's Clinical Medicine, 1843, p. 452; Vincent, Observations on Surgical Practice, Lond. 1845, p. 105.

for him to put out his tongue, and his countenance has a peculiar expression, resembling a painful smile, because the corners of the mouth and eyes are drawn outwards by incipient spasm of the facial muscles. In the next place, the muscles of mastication and deglutition become fixed and rigid with spasm, so that the mouth is permanently closed, and there is great difficulty of swallowing, especially liquids. To these symptoms succeed a fixed pain at the pit of the stomach shooting to the back, and a convulsive difficulty of breathing, indicating that the diaphragm and muscles of the glottis are affected; and the spasm now extends to the muscles of the trunk and limbs, rendering them completely fixed and rigid. The abdomen feels remarkably hard; there is obstinate constipation, and frequently difficult micturition from spasm of the perinæal muscles; the pupils are contracted; and the saliva flows from the mouth, because the patient is unable to swallow it. This spasm never ceases entirely; but it occasionally has a lull, and then comes on again in fits of greater violence. Such fits are easily brought on by any disturbance, such as an attempt to swallow, or by any other bodily movement or mental excitement, and most remarkably by slight causes affecting the surface of the skin; such as currents of cold air. There are generally some snatches of relaxation during sleep. Meanwhile the intellect is undisturbed, and the pulse may be natural, except during a severe paroxysm, which quickens it, and causes perspiration and thirst.

TERMINATIONS.—(1.) If the case is about to end *fatally*, the paroxysms become more frequent and violent, and the breathing more and more embarrassed by spasm of the diaphragm and of the muscles of the glottis; and at last the patient dies, either from exhaustion or from suffocation;—either because the nervous system is worn out by the violence of the spasm; or because the respiration is suspended long enough to cut off the necessary supply of arterial blood from the brain, and so to induce insensibility. The most usual *period of death* is the third or fourth day; sometimes it is postponed till the eighth or tenth, but rarely later. On the other hand, there is the case* recorded of a negro who injured his hand, and died of tetanus in a quarter of an hour; and cases of death within twenty-four hours are by no means uncommon. (2.) When acute tetanus terminates favourably, still the patient's recovery may not be complete for weeks or months;—partly because of the strainings and lacerations which the muscles have suffered,—partly because of the remaining tendency to spasm, which very slowly yields and is apt to be temporarily aggravated by very slight causes, especially cold and damp. But in some rare instances the disease has been removed almost instantaneously by the removal of its exciting cause.

PROGNOSIS.—The prognosis in acute tetanus is extremely unfavourable, especially if traumatic; it is more favourable in the idiopathic, and the chronic generally gets well of itself. Death very seldom occurs after the twelfth day. As a general rule, it may be said that the prognosis is *favourable* if the complaint is partial;—if it does not affect the

* Rees's Encyclopædia, *Art.* Tetanus.

muscles of the glottis;—if it has lasted some days without increasing materially in severity;—if it is sensibly mitigated by the remedies employed;—if the pulse is not much accelerated;—if the patient sleeps;—and if he has been subject to it before in an intermittent form. On the other hand, the prospect will be *unfavourable*, if the spasms continually increase in severity, and especially if they affect the muscles of the glottis.

DIAGNOSIS.—Tetanus may be distinguished from *hydrophobia* by the spasms being *continuous*, and by the patient being in general sensible, and calm to the last;—whereas in hydrophobia, there are fits of general convulsions with *perfect intermissions*, and the patient is mostly delirious. *Inflammation of the spinal cord*, or of its membranes, may be distinguished by the pain in the back and fever, and by the paraplegia and coma which supervene in most cases.

MORBID ANATOMY.—The morbid appearances that have been found in different cases are as follow:—Increased vascularity of the membranes and substance of the *spinal cord*, with or without effusion of serum;—more rarely the same appearances may be found in the cranium;—flakes of cartilage and spicula of bone deposited in the membranes of the spinal cord;—vascularity of the nerves leading from the wounded part;—of the mucous membrane of the stomach; and of the sympathetic ganglia;—and congestion of the lungs. But there is not one of these morbid changes that is constantly, and except the first, there is not one of them that is even frequently, found. The muscles are extremely rigid after death, and ecchymosed or ruptured in many parts;—the blood is mostly uncoagulated.

CAUSES.—Tetanus may be caused by wounds and external injuries of every description, but especially by lacerated and punctured wounds of the hands and feet, gun-shot wounds, compound fractures, compound dislocation of the thumb, and wounds irritated by foreign matters, or in which nerves are exposed. Mr. Morgan knew it even caused by a blow with a schoolmaster's ferule; but it is very rarely caused by clean simple incisions. The period at which it may come on after an injury is very uncertain. Sometimes it occurs very quickly, if the patient is predisposed to it. Sometimes it seems to be induced by the great pain and irritation of a wound during its inflammatory state: but the most common period is, when the wound is nearly healed.

It seems probable that some concurrent or predisposing cause, in addition to an external injury, is required to produce tetanus. Of such causes, the best established are, 1st, an irritated state of the bowels, from retained fæces;* and, 2ndly, exposure to draughts of cold air, or

* For cases arising from intestinal irritation, vide Med. Gaz. vol. i. p. 646; Med. Chir. Trans. vol. vii. p. 459; Ibid. vol. vii. p. 474, et seq.; Abernethy, Lectures on Surgery, London, 1835, p. 23; Travers, Further Inquiry concerning Constitutional Irritation, London, 1835, p. 397; Fournier-Pescay, Dic. de Sc. Med. Paris, 1821, vol. lv. p. 9; Wincelslai Trnka de Krzowitz, Commentarius de Tetano *Vindobonæ*, 1777; Dictionnaire de Médecine et Chirurgie Pratiques, Paris, 1836, *Art.* Tetanos; B. Gooch, Chirurgical Works, Lond. 1792, vol. ii.

to cold damp night air during warm weather, or in a warm climate; consequently, tetanus is much more prevalent and fatal in India and other warm than in cold or temperate climates.

The same causes, cold and visceral irritation, namely, which predispose to the traumatic, may of themselves produce the idiopathic tetanus. Thus the latter may be a consequence of various visceral irritations, especially of the womb. Whytt gives the case of a girl, aged twenty, who caught cold during the menstrual period, and died of tetanus in eighteen hours; and the author knows a case in which fatal trismus followed abortion.*

Tetanus may also be caused by certain poisons, especially the nux vomica.

PATHOLOGY.—The spasms of tetanus affecting as they do all the voluntary muscles, must evidently depend on some morbid condition of that central organ, the spinal cord and medulla oblongata, from which all the voluntary muscles are supplied with nerves. What that condition is, is unknown. It is most probably dependent on a peculiar state of blood, inasmuch as we know that when blood containing strychnine circulates through the nervous centres, it causes tetanic symptoms. There is the further argument from analogy, that inasmuch as chorea has a decided alliance with rheumatism, so may tetanus with some similar blood-disease. Or it may depend on some disturbance in nervous action, independently of the blood, of which we are profoundly ignorant. Such nervous disturbance may be *centric*, that is, may depend on causes affecting the spinal marrow itself; or *excentric*, that is to say, may depend on irritation of some other part of the body, which irritation is conveyed to the spinal cord by the *sentient* or *afferent*, or, in Dr. Hall's language, *excito-motor* nerves.

It is quite certain that the morbid condition cannot be regarded as inflammatory in the ordinary sense of the word, because the spinal cord is often found after death without a trace of vascularity, and because tetanus may be established during a state of depression and collapse that would be quite incompatible with inflammation.

Although, however, it is most certain that inflammation is not essential to the existence of tetanus, still it is equally certain that there is one class of tetanic cases which presents a well-marked inflammatory character. They commence with shivering and pain, are attended with fever, and, if fatal, display on inspection, congestion, serous effusion, softening or purulent deposit, in some part of the brain or spinal cord.† But this class is a small one.

TREATMENT.—The indications are, 1st, To remove, so far as we are able, all conditions, known or believed to have the power of creating the tetanic state; 2nd, To give the patient every chance of spontaneous recovery, by husbanding his strength till the disease shall cease of itself; 3rd, To use any special sedative or other treatment, which the surgeon

* See Cooke's Morgagni, vol. i. p. 129; and the Lancet for June 2nd, 1838.

† For cases of inflammatory tetanus, vide Med. Gaz. vol. i. p. 645; Fournier-Pescay, op. cit.; Burmeister in Med. Chir. Trans. vol. ii.

would sincerely desire to have employed on himself if he were the patient.

In the *local treatment*, the first points to be accomplished are, to remove all extraneous bodies from the wound, if there be one; to make incisions, if necessary, for the free discharge of pus, or for the relief of inflammatory swelling and tension; and if any isolated portion of nerve or tendon happens to be on the stretch, to divide it. Then the part may be fomented with warm decoction of poppies; after which, warm opiate or belladonna lotion may be applied on lint, and the whole part be enveloped in large hot poultices. Sundry other measures have been proposed in order more effectually to remove local irritation; such as the division of the principal nerve leading from the wound; or, as Mr. Liston proposed, the making a A incision above, so as to isolate it and cut off as much nervous communication as possible; or the destruction of a ragged, contused, ill-conditioned wound by *actual cautery*, as Larrey and others have practised with great benefit; or the *excision of the wound* if cicatrized or nearly so. Sometimes, when the wound is nearly cicatrized, or has ceased to suppurate, the application of a blister or of strong stimulating ointments has appeared to be of service; but, as Mr. Curling* observes, it happens, unfortunately, that the tetanic condition of the spinal cord, when fully established, is mostly independent of its local exciting cause, and does not cease on its removal. Hence *amputation* of the injured part has very rarely been successful, and has even aggravated the mischief; so that it ought not to be performed, unless desirable for some other reason besides the tetanus.

Purgatives are indicated, if there is evidence that the liver and bowels are loaded, because a loaded state of bowels is known to be a cause of many morbid conditions of the nervous system, and because, possibly, they may eliminate some unnatural element in the blood. Thus, a powder of calomel and jalap mixed with butter may be put at the back of the tongue, for the patient to swallow, and may be followed in an hour with a large dose of castor oil; and enemata of turpentine may be administered until the desired effect is obtained, which is the ridding the bowels of black offensive matter. But it is not only useless, but mischievous, to irritate empty bowels, and bring away mere inodorous serum or mucus.

The above are measures employed to remove causes, according to the first axiom in the treatment of all diseases. But after adopting such of these as shall be expedient, the next thing to be attended to, on which all authors agree, is the necessity of observing perfect quiet, and avoiding all irritation and disturbance. The room should be dark; the patient should neither speak, move, nor swallow oftener than he can help. The administration of remedies should be effected as gently as possible. Everything harsh and violent should be avoided. The cold affusion, and the extraction of a tooth in order to admit an œsophagus tube, have

* A Treatise on Tetanus, being the Jacksonian Prize Essay for 1834, by T. Blizard Curling, London, 1836, p. 122.

such been known to cause death suddenly. If nourishment cannot be swallowed, it should be given *per rectum*. (See *Nutrient Enemata, Soups, &c. in the Appendix.*)

In all cases an abundant supply of nourishment should be given, with wine or brandy. In some cases recovery has followed the use of spirits in large quantities.* It may seem expedient to add quinine, or muriated tincture of iron, if the debility be very marked.

When considering our third head of treatment, we must remember that it is not because a patient gets well after any given remedy that we are to pronounce him cured by it. "Tetanus," says Mr. Poland, "runs a certain course: it has its period of accession, its height and stage of activity, and its gradual decline; it often kills before it reaches its active point, and often kills by exhaustion during its decline. Nothing seems to check its regular course. All we can do is to enable our patient to weather out the storm by giving him as much strength as possible."† Yet it cannot be wondered at that surgeons have again and again tried those sedatives which seem likely to be of service.

Cold is said to have been of service to animals affected with tetanus; and a soldier was once most unexpectedly cured after exposure all night in severe weather. Cold was applied to the spine by Dr. Todd by means of bladders, or ox-gullets filled with ice. Ice to the spine is also proposed by Dr. Chapman; but further experience is wanted.

Warm baths, or vapour baths, seem rational remedies, yet are not proved to have done any service.

Opium has appeared of most undoubted efficacy in some instances, probably those attended with a painful wound, and weakness. When it produces good effects, they are soon manifest. It may be given in large doses, in the form of enema or suppository; but it must be confessed that in most cases it is useless or inert.

Chloroform.—This seems a promising remedy, and in several cases has been of real service; in others, on the contrary, either it has soon lost its power of mitigating the spasms, or else it has nauseated, or else, although the spasms have been subdued, the patient has died, from exhaustion, or from some inscrutable alteration in the nervous centres.‡ The dose should be small, and continuous.

The *Indian Hemp* has been employed with very good effects, by Dr. O'Shaughnessy and others at Calcutta, and by several practitioners in this country (P. 29).

The *curara* or *woorali* poison, which paralyses the motor nerves, and acts as an antagonist to strychnia, was proposed many years ago by Mr. Waterton, the naturalist—a proposition supported by experiments

* See some observations by Dr. Todd, quoted in Ranking, x. 33.

† Alfred Poland, Report of seventy-two cases of tetanus, occurring in Guy's Hospital since 1825, Guy's Hosp. Rep. vol. iii. 1857.

‡ See two cases by Dr. Cotton of Lynn, Prov. Med. Jour. May 15, 1850; fatal, though sufferings relieved by ether and chloroform inhaled; case by Mr. Sloman of Farnham, quoted in Ranking's Abstract, x. 36; chloroform soon lost influence; patient recovered under calomel *and morphine*. See Anstie on Stimulants, Lond. 1864.

on tetanic animals. It has been used of late years by Vella, Manec, Chassaignac, and Spencer Wells. The results are not satisfactory.*

Tobacco is an old remedy, and one the action of which seems antagonistic to tetanus. But it was tried forty years ago with the usual result; that is, it seemed to do good in some cases; in others, though it may have relieved the symptoms for a time, it failed to save life; and in others, it acted as a decided poison. Latterly it has been carefully investigated by the Rev. Professor Haughton,† who has shown that nicotine, its active principle, is really an antidote to *strychnia*, in *cold-blooded* animals; and has again urged its employment, and has employed it in tetanus. The results seem scarcely more satisfactory than of old; but probably much is to be done yet in regulating the dose. The dose of nicotine should probably not be more than half a drop, at intervals of four hours. Certainly *if* any remedy be worth trying it is this. But the author declares that if he himself were patient, he should trust to nourishment, quiet, and wine, and desire to have no specifics tried.

SECTION III.—CHRONIC AND INFANTILE TETANUS.

CHRONIC TETANUS is very seldom fatal, although in some rare instances the patient has died completely exhausted by its long continuance; for it sometimes lasts several weeks. The principal remedies are aperients, tonics, chloroform, and the shower-bath. The bowels should be kept freely open, but not by too drastic medicines. Electricity, in the form of sparks, or weak shocks, or Faradisation down the spine, would probably be of service.‡

TRISMUS INFANTUM is a form of tetanus which is almost unknown in England. It was formerly, however, exceedingly prevalent in Ireland, and appears to be met with there occasionally, even at present. It carries off a vast number of children in the West India Islands; and we learn from Sir H. Holland, that in the desolate rocky Vestmann islands, on the south coast of Iceland, one hundred and eighty-six infants perished of it in twenty-five years, although the population does not exceed one hundred and fifty souls. The causes appear to be, want of ventilation, and filth; or the innutritious and unwholesome diet of the parents, such as the fish and sea-bird eggs that form the only sustenance of the Vestmann islanders; and the use of irritating applications to the wound left by the falling off of the navel-string. The time at which the disease appears is generally from the fifth to the tenth day after birth; hence the popular Irish term, *nine-day fits*.

* For an account of Woorali, see Waterton's Wanderings in South America, 5th Ed. London, 1852. An ass poisoned with woorali, and kept alive by artificial respiration, survived for 25 years. Brodie's Papers in the Phil. Trans. for 1811, p. 178, and 1812, p. 205; Morgan's Lecture on Tetanus; Claude Bernard, Lectures in Med. Times and Gaz. 1859; Spencer Wells, Three Cases of Tetanus, Proceedings of Royal Med. Chir. Soc.

† Medical Times and Gaz. Jan. 12, 1858; Oct. 25, 1862; Jan. 31, 1863; J. W. Ogle, *ib.*, Mar. 12, 1864.

‡ Addison on Electricity in Convulsive Diseases, Guy's Hosp. Rep. vol. ii.

The *symptoms* are, locked-jaw, spasmodic difficulty of breathing and swallowing, and general convulsions. They are almost invariably attended with diarrhœa, and preceded by fretfulness, startings during sleep, and unusual greediness for the breast.

Treatment of any kind is seldom successful; but it may be presumed that the warm bath, four or five doses of calomel (gr. i.—ii.) at intervals of four or five hours, a teaspoonful or two of castor oil to clear the bowels, and minute doses of laudanum (one-eighth of a minim, cautiously increased) every two hours afterwards, or chloroform, are the measures most likely to be of service.*

CHAPTER IV.

HYSTERIA AND HYPOCHONDRIASIS.

I. HYSTERIA is a profound disturbance of the nervous system, most usually affecting women, but not unknown in men. Our limits prevent us from treating of it further than as it is an occasional complication of surgical disease; suffice it to say that it seems to consist in an exaggeration or disturbance of the emotions of the mind, and in the sensitive functions of the body; and that it may ensue upon disturbance of health of any kind, mental suffering, delay in the development of the generative organs, or some chronic form of mal-assimilation, such as a latent gouty or rheumatic taint. It is remarkable for the great diversity of symptoms it may cause, and of the diseases it may simulate. Mental disturbance of all kinds, from the most vivid delirium to the most profound torpor; muscular affections ranging between utter palsy and frightful spasm; disturbance of sensation, including the most violent pains and the most perfect numbness; irregularity of the circulation, of the digestion, and of every other function are among its effects.

II. As an illustration we may refer to HYSTERICAL TETANUS. A female may be seized with stiffness of the muscles of the face and jaws, which may extend to the neck, and gradually invade the trunk and limbs, so as completely to close the mouth, and render the whole body rigid and motionless. The chief points of diagnosis are, the hysterical state of the mind; and the fact that the muscular contraction, however great, may almost always be overcome for the moment by forcing the patient to exert her volition. The best remedies are gentle aperients, valerian, and other antispasmodics, and henbane.

III. HYSTERICAL NEURALGIA.—Hysteria is apt to cause fits of pain, which simulate various acute or chronic diseases. Sometimes it is violent pain in the head, with stupor; sometimes pain in one side, in

* See a Paper by Joseph Clarke, M.D., in Med. Facts and Obs. vol. iii. Lond. 1792; Sir H. Holland's Med. Notes and Reflections, 2nd Ed. p. 29; Maunsell and Evanson on Diseases of Children, 4th Ed. Dublin, 1842, *p. 219*; and Maxwell on Yaws and Tetanus, Edin. 1839.

the seat of pleurisy; sometimes pain and tenderness of the abdomen. Now although the patient may describe the sensations of pleurisy or peritonitis, and very likely may feel them, yet positive physical signs are absent, and many symptoms may be elicited by art which are quite incompatible with the existence of serious organic disease. Thus the patient with hysterically simulated laryngitis, though breathing fast and noisily, if she speak, may speak without hoarseness, and will not display in the face the signs of approaching asphyxia. A patient with hysterical pleurisy will expand the ribs freely; and in hysterical peritonitis, as in other hysterical diseases, the patient flinches from a slight touch, and yet, if her attention be engaged, will bear firm pressure without complaint.

In the same manner, any one of the limbs or joints may be affected with pain, tenderness, and spasm, as if one of the joints were diseased; or there may be pain in the spine, with great sensitiveness of some particular vertebra, tympanites of the belly, and difficulty of making water, or irritation along the nerves corresponding to the vertebra affected; a condition known as *spinal irritation*.

As we are not writing a treatise on Hysteria, but merely giving some hints on the possible difficulty of diagnosis arising from its presence, we will only remark, in addition to the exaggeration of the sensational symptoms, and the absence of physical signs, that the practitioner should notice the hysterical physiognomy, and consider whether the duration of the symptoms accords with that of known diseases.

There are two mental conditions generally found in hysteria, although they are not peculiar to it, but belong rather to *invalidism* in general. One is a tendency to imitation, in which the patient believes that he or she is afflicted with any disease whatever which may strike his imagination, or which he chances to hear of, or which is the subject of general conversation. The other is a diseased egotism, which makes the patient delight in being ill, so as it secures the undivided attention and sympathy of those about her. This is at the bottom of those marvellous and otherwise unaccountable tricks which hysteric patients resort to in feigning disease.

TREATMENT.—Our limits do not allow us to do more than glance at this part of a very large subject; but we may observe—

1st. That there are no drugs which are specifics for hysteria, but that every case must be treated on its own merits. The state of the digestive organs, of the colon, of the urine, and uterine function; of the blood, whether impoverished or not; and of the mind, must all be regarded. Aperients, good diet, and, above all, change of residence, and warm aromatic medicines, especially valerian, are the measures most likely to do good.

2ndly. That all *heroic* measures, leeches, blisters, issues, setons, examinations with the speculum, and other things justifiable in cases of true organic disease, do infinite harm in hysteria.

3rdly. That warm soothing liniments, as F. 148, &c., are the best local applications.

We will conclude with three rules, which we entreat the young practitioner to observe, assuring him, from ample experience, that they will save him much trouble.

1st. Be sure that you do not treat hysterical sensations as organic disease. If you do, you lead the patient into endless debility and trouble; especially if it is the womb which is believed to be diseased.

2ndly. Never treat an organic disease as if merely hysteric. If so, you may lose your character and the patient's life or limb.

3rdly. Remember, that organic disease may exist, and hysteria too; and that the presence of hysteria is no proof that the whole case is hysteric. Therefore, in any case of local pain, long continued, if the health and flesh fail, suspect that there may be some organic cause, though the bulk of the symptoms be hysteric. To order sea-bathing and horse-exercise for an hysterical girl with pain in the back, and to discover vertebral caries afterwards, is not good. Here is a practical rule. If a patient gets fat or keeps so, the diagnosis of hysteria is probably right: if she lose flesh, the search for organic disease should be renewed.*

IV. HYPOCHONDRIASIS is a low, desponding state of mind, generally accompanied by a vitiated state of blood and imperfect excretion, or by some cause of exhaustion. The patient is apt to imagine himself the prey of a variety of diseases. By way of example we may refer to Syphilophobia.

A patient consults the surgeon, assuring him that he is labouring under a severe and confirmed secondary syphilis. On being questioned, it may be found that there is no satisfactory evidence that he has had primary syphilis; and he will point to a small pimple as his secondary symptoms. He ascribes every sensation, however innocent, to the working of the poison in his veins, and cannot be convinced to the contrary.

The three rules we have laid down regarding hysteria are here of immense utility. A patient may be fanciful, yet his maladies may not be *all* fanciful, and the surgeon who overlooks this possibility is guilty of carelessness and cruelty. One more rule we must lay down with respect to confirmed hypochondriacs—*Never attempt to argue them out of their belief.* If the diseased sensations could be argued away, the patient need not have come to you. Treat the case on the principle, that the patient's sensations and mental powers are disordered by serious aberration in the bodily health, or by some mental trouble; it may be grief, or low living, or exhausting fatigue, or a gouty taint. Do not ridicule or ignore the patient's statement. Many an inexplicable sensation, put down to *nervousness*, has been the forerunner of organic disease. Therefore, examine the local symptoms carefully, and if you find no local disease, treat the general health on common principles.

* See T. Holmes, Path. Trans. 1863, xiv. 12; case of hysteria with spasms and disordered sensation in legs; death; *post mortem* tubercle, found in spinal cord.

CHAPTER V.

CONVULSIONS.

In order to complete the view of nervous disorders produced by local injury or disease, it is necessary briefly to allude to *convulsions*, occurring in epileptiform paroxysms. These are familiar in *medical* practice, when arising from [illegible] of the stomach, of the uterus, &c.; they also o[illegible] some of the local affections which custom has [illegible]on. In particular, they may arise from spicula[illegible]he inner surface of the skull; or from slight inj[illegible] have left the bone unsound; and especially from [illegible]y organs; retention of urine, renal calculus, and th[illegible] convulsions are apt to be produced by severe injur[illegible]y kind, at the time when the nervous system is beginning [illegible]ed.

The *symptoms* it is not necessary to describe in this place. As to the *treatment*, the following are the main indications: 1. To search for, and remove, or soothe any external source of irritation. 2. To evacuate disordered secretions. 3. To lessen accumulation of blood in the central organs of the nervous system, if it exist, as indicated by firm pulse, and turgid lips, eyes, and countenance. Ice to the head, and mustard to the feet, are almost equivalent to a cupping. 4. In the opposite class of cases, with feeble pulse, pale face, and dilated pupil, to give beef-tea and brandy. 5. In all cases to give sufficient nourishment.

PART II.

ELEMENTARY PROCESSES OF DISEASE AND REPAIR.

CHAPTER I.

MALFORMATION, HYPERTROPHY, ATROPHY, AND DEGENERATION OF TISSUES.

I. CONGENITAL MALFORMATION.—In the present part of our work we propose to give a general view of the various changes of form or of structure which may be met with in any part of the body, from any cause interfering with the regular processes of nutrition and function. Amongst these, the earliest in point of time, are the various original malformations, which occur through defects in the germ out of which the fœtus is developed. Of such malformations, some depend on an *arrest of development*, through which various organs, or parts of organs, are left, as it were, incomplete and unfinished. Such are the cases, which come under the surgeon's notice, of *spina bifida*, or incomplete closure of the arches of the vertebræ; such are *hare-lip* and *cleft-palate*, which arise from a similar condition of the bones and soft part of the face;—such, too, are *epispadias*, and *hypospadias*, or incomplete closure of the receptacle and ducts provided for the urine. From a like want of development, though the immediate effect is opposite, arise the conditions of *imperforate anus*, or *vagina*.

Other cases of congenital deformity are caused by local *excess of development*; such as, for instance, supernumerary toes and fingers. Others, again, arise from defects in the original constitution of the ova; so that one fœtus becomes adherent to another; or even becomes included within the body of another.

Of the causes and prevention of congenital deformities, it is not worth while to speak. Of the treatment of such as are capable of relief by surgical means, mention will be made in PART IV., in the chapter devoted to the organ in which each variety may occur.

II. INTRA-UTERINE DISEASE.—Children are sometimes born with deformities which ought to be distinguished from those mentioned in the preceding paragraph, insomuch as they do not result from any defect in the germinal power of development, *but from diseases* occur-

ring to the fœtus, which produce within the womb the same effects that they would produce at any other period of life. Such are the congenital club-foot, and dislocation of the hip; and those very curious instances of spontaneous amputation, so called, in which one of the limbs of the fœtus becomes tightly entangled in a loop of the navel-string, or in an accidental band of lymph, and is strangulated and cut off in consequence.*

III. HYPERTROPHY.—This term signifies not merely an increase of bulk, or swelling of an organ, but an increase in size, depending on an increase in its healthy structure. Genuine hypertrophy, too, is usually attended with increased *development;* that is, with the unfolding of a higher order of structure, so that the hypertrophied organ acquires new and greater powers. It is often a healthy and conservative process, whereby the hypertrophied organ is enabled to do more than its ordinary share of duty, and to compensate for some deficiency in some other part of the economy.

"The *causes* are," as Mr. Paget observes, "chiefly these three. 1. The increased exercise of a part in its natural functions; 2. An increased supply of healthy blood; 3. An increased accumulation in the blood of the particular materials which any part appropriates in its nutrition, or in secretion."

(1.) Instances of hypertrophy from the first cause specified are afforded by the bladder, which, in cases of obstruction to the passage of urine, becomes greatly more capacious, with its mucous and muscular coats developed into a state of greater power, fitting them for the increased pressure they are obliged to bear and to exert;—by the cuticle, thickened by pressure and friction; and by the bursæ developed, under like conditions, in the areolar tissue.

(2.) Instances of hypertrophy from increased supply of healthy blood are afforded by the growths of hair which sometimes take place in the skin in the neighbourhood of ulcers; and by the elongation of one of the bones of a limb of a growing child, which sometimes occurs when a vascular ulcer of the skin, or disease of an adjoining portion of bone, has for a considerable time caused an unusually copious current of blood to circulate in the vicinity.

(3.) Hypertrophy caused by a particular condition of the blood is exemplified in the increase of one kidney, which occurs when the other is incompetent, through disease or injury, to abstract its share of urinary matter from the blood. The ossifications which take place in the legs of certain breeds of horses are owing probably to the same cause, so perhaps is goître; the obesity of great eaters certainly is.

(4.) Lastly, hypertrophy may arise from some disturbance of the forces of growth or development, whereby a portion of a bone, or of the fatty tissue, will grow disproportionately to the rest of the body. What the nature of the force is which presides over growth in

* See case by the Author, Obstetrical Trans., vol. ii. p. 135, of obliteration of portions of the small intestine by bands of lymph, from peritoneal inflammation in the fœtal state.

general, and gives it its limits, and insures harmony and proportion amongst the various growing parts, is unknown. If we appeal to the organic nerves which regulate the diameter of the capillaries and the distribution of blood, we then require to ask what influences the nerves—what makes the mammæ, for example, grow at puberty and during pregnancy, and not at other times. One thing is certain, that hypertrophy, *per se*, is no sign of general excess of force, but may be of the contrary; for example, the large hands and feet and joints of ill-nourished children, and the big brain and thyroid gland of the rickety and anæmic.

The *treatment* of hypertrophy must consist in removing the causes, if possible.

IV. ATROPHY is the reverse of hypertrophy; it is the wasting of an organ in size.

V. DEGENERATION.—This may be defined to be the loss of the proper structural characteristics of an organ; or the substitution of a lower for a higher form of tissue; so that degeneration differs from pure atrophy, although some amount of it is usually superadded.

The chief forms of degeneration are—1st. The *obese*, in which there is a development of fatty tissue, occupying the place of muscle, or some other higher tissue. This is often seen in the heart.

2ndly. The *fibrous*, in which fibrous tissue, often imperfect or *fibroid*, is substituted. There is also a kind of degeneration called the *waxy* or *lardaceous*, and another closely allied, called the *amyloid*, in which an obscurely fibroid, or almost amorphous substance, resembling starch in some of its reactions with iodine, is infiltrated into or substituted for certain tissues, especially the liver and spleen.

3rdly. The *fatty*, or *oily*, which does not consist in development of fatty *tissue*; but in decay or molecular death of the proper substance of an organ, and its conversion into a mass of granules, mixed with oil globules and crystals of cholesterine.

4thly. The *earthy*, or calcareous, common in the placenta; in which after decay and solution of a tissue, or more probably of some exudation which has infiltrated it, there remains a *crystalline* mass of carbonate and phosphate of lime, with traces of magnesia. This, although commonly called ossification, is not so really, as the earthy matter is amorphous or crystalline, and not disposed in the form of bone tissue. Yet there are instances in which true bone is developed in fibrinous exudations, as in the ear and eye. So the ossification of cartilage is a senile degeneration.*

5thly. The pigmentary, in which there is an accumulation of black matter.

The fatty degeneration is liable to affect the muscles, and particularly the heart; it may occur in the cornea of the aged, the lungs of the emphysematous, the kidneys of those who die of Bright's disease, and in every variety of cell growth and tumour. It has no connexion with general obesity.

* See Toynbee, Ossification of Ear, Path. Trans. 1860, vol. xi., p. 224; Obré, True Bone in Eye, ib. p. 225; also Ernest Hart, ib. vol. xiii. p. 212.

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The *causes* of atrophy and degeneration are—1st. Disuse, or want of exercise, which is sure to cause any organ to waste.

2ndly. Diminished supply of blood may in some cases cause atrophy, as in others it causes ulceration or gangrene; but an organ whose vitality is active is almost sure to attract blood enough to itself, if there is no utter physical obstacle to the current.

3rdly. Deficiency in the blood of the materials necessary for healthy growth and nutrition of an organ is a third cause. This may be exemplified by the atrophy of bone and muscle when there is an insufficient supply of food, or when the materials necessary for them are wasted by undue secretion.

4thly. Deficient vitality; deficiency of that power by which every organ is enabled to maintain its growth, and to abstract from the blood the materials for its nutrition. This again may be caused by exhaustion; by excessive fatigue; by over use or abuse of a part; by disease, which has spoiled its tissue; and by injuries to the nervous centres or trunks supplying it.

The *treatment* will be exemplified under the heads of atrophy of muscle and of bone.

VI. SENILE DECAY.—As man is born for a limited term of life, so each separate part of his organism, when it has attained perfection and answered its appointed purposes, begins to show symptoms of decay;—thus giving us warning that death must occur sooner or later from mere inability of the organs any longer to carry on the processes of life, even if it be not hastened by violence or disease. Some of the changes which take place in consequence of age, in the eye, the teeth, the prostate gland, and the bones, are subjects of surgical study, and will be detailed in the fourth part of this work.

It must be added that when we speak of *senile* decay, we speak of a thing "not to be measured by number of years," for some men at fifty are in all respects older and worse in constitution than others who are thirty years their seniors. It must be added, likewise, that some instances of wearing out may occur at quite an early age, as, for example, the decay of the hair and teeth; and that peculiar change in the veins which is known as varix, when they become distended and knotty from inability to support the column of blood contained in them.*

CHAPTER II.

HYPERÆMIA.

HYPERÆMIA.—Although preternatural accumulation of blood plays a most important part in that series of phenomena known by the term *inflammation*, yet it does not by itself constitute inflammation; and we have devoted this short chapter to the subject *per se*, in order that

* For fuller information on the subjects of this chapter, consult Mr. Paget's Lectures, and Andral's Pathological Anatomy, trans. by West and Townsend.

the student may be aware that a something above and beyond this is necessary to constitute inflammation, as will be shown hereafter.

Local hyperæmia may be of two kinds—1. Active or arterial; 2. Passive or venous. To the first the name *determination of blood, or active congestion*; to the second the name *passive congestion* is commonly given.

1. *Active determination* of blood is a process wherein more blood is attracted to some particular organ, and circulated through it more rapidly than usual. It is necessary to many natural and beneficial actions: as the enlargement of the womb in pregnancy, and of the breasts after delivery. It is equally necessary to many morbid actions; it forms one of the first and most palpable effects of inflammation; it is the cause of redness and throbbing; it is witnessed in blushing; in the condition of the blood-vessels of the intestines in malignant cholera; in headaches from excitement; and in the afflux of blood to the uterus, from ovarian excitement. The usual consequence of active hyperæmia in excess is hæmorrhage; as in sanguineous apoplexy, epistaxis, and hæmoptysis.

2. *Passive congestion* signifies a stagnation of blood in a part, especially in its veins. It may be a consequence of mechanical obstacle to the return of blood; or of atony and want of vital contractility in the capillaries, especially if they have been previously subject to great distention or excitement. It is evidenced by a sense of weight and aching pain, and is very liable to lead to serous effusion, or passive hæmorrhage, and to ulceration or gangrene.

There are two causes of peculiar force in producing local accumulations of blood. One is the condition of the nervous system, the other the composition of the blood. For example, mental emotion will direct currents of blood to the lachrymal glands in weeping, to the salivary glands in hunger, to the breasts, uterus, and other sexual organs. Some women flood if their tempers are disturbed. The fixing the attention strongly on any organ may suffice to derange its circulation. The administration of opium warms the feet and produces a genial circulation in the skin. It appears by the experience of Brown Sequard, and Claude Bernard,* corroborated by those of Dr. Chapman, that whatever paralyses the sympathetic nerves, produces dilatation of the blood-vessels to which those nerves are distributed. Section of the sympathetic in the rabbit's neck, causes the arteries of the ear and side of the face to enlarge. The other cause is impurity of blood. Let the blood be impure from any cause whatever, from the presence of bile, urea, or lithic acid, or let it be deficient in its proper constituents, or let it be contaminated by poison, and local congestions are sure to occur. Every poison seems to have its own seat of election. The headaches that accompany biliary disorder, and the serous effusions which follow Bright's disease, the stomach irritation from arsenic and the paralysis from lead, are examples.

* See Claude Bernard's Lectures in the Medical Times and Gazette for 1860 and 1861.

CHAPTER III.

NERVOUS PAIN.

As all hyperæmia is not inflammation, so neither is all pain. Pain may arise from muscular spasms or cramp, or from some diseased condition of the nerves, or of the nervous centres, without the existence of the least inflammation. Such pain, nervous pain, as it is commonly called, may often be known by its capriciousness; by its coming and going without apparent cause, or with no other cause than the patient's mind being directed to it. It is often intermitting. It is often relieved by measures that would aggravate inflammation, such as stimulants, pressure, and friction; and almost infallibly aggravated by leeches, blisters, and other remedies that would relieve inflammation if it existed. It is often intense in proportion to the anæmic and debilitated condition of the patient. It is often intense out of all proportion to heat, swelling, and redness, even if they are present at all. In its character it is often violently plunging or shooting, and is compared by the patient to the running through of a red-hot wire, or the passage of an electric shock. It may last for weeks or months without being followed by any of the changes of structure which are commonly called inflammatory. Lastly, it may be felt in parts quite remote from any morbid action, or may be referred to parts of the body destitute of sensation (thus after fracture of the spine severe pain has been felt in the legs, though quite insensible to the touch), or may be referred to parts that have no existence, of which the pain felt in limbs long since amputated may be an example.

The *treatment* of this condition will be found in Part IV., under the head of Neuralgia.

CHAPTER IV.

EXUDATION, CELL GROWTH, AND GENESIS OF DISEASE.

THERE are few surgical diseases in which the part affected does not suffer enlargement or tumour. Some kinds of tumour are caused by *mechanical* conditions, as the enlargement of arteries in aneurism, that of veins in varix, that of hernia, or protrusion of the bowels, &c. Some other tumours may be caused by the intrusion of air, as in emphysema, or of blood, as in ecchymosis, or of serum which has oozed from distended veins, as in œdema. But there are other swellings, which seem to depend, not on mere misplacements or mechanical conditions, such as the foregoing, but on increase of the structural element of the part affected, or upon the *presence within it of structural elements* in various states of development which often seem to be intruded into it. Of this kind of tumour are 1st, The hypertrophies,

which consist in an increase of a natural tissue or structure; 2ndly, The changes which follow injury, and lead to repair; 3rdly, Those called inflammatory; 4thly, Those called tubercular: 5thly, Those leading to the establishment of various tumours more or less resembling the areolar tissue, the glandular, the epithelial, and some of the embryonic forms of these tissues.

Now in all these cases, except hypertrophy, if the part affected be examined at certain stages, it will seem to be infiltrated with a material which is undergoing development. In the case of *repair*, the material is converted into areolar or tendinous tissue, bone, &c. In the case of inflammation, it constitutes the well-known inflammatory effusions and adhesions, and often undergoes conversion into pus. In the case of tubercle, the new material soon undergoes fatty and calcareous degeneration, and withers into a cheesy mass. In the case of tumours, it undergoes development into a great variety of forms which are enumerated in their place.

1. Till of late, it was taken for granted that the new matter was strictly an "effusion," or "exudation" of coagulable lymph or plastic matter from the blood; that the new material, for example, which unites the ends of a divided tendon or broken bone, or which fills up the hollow of an ulcer, was given out from the blood-vessels, and that the cell growths found in it were developed in it. It was held that self-generated molecules in the lymph aggregated themselves into nuclei, nuclei formed cells, and cells grew and developed themselves into tissue. All this was supposed to be accomplished in, and by the forces inherent in, that spontaneously coagulating part of the *liquor sanguinis* commonly called fibrine, fibrino-plastic matter, *plasma*, *blastema*, &c.

2. On the other hand, a more modern school contends, that, although the blood certainly furnishes the passive substance out of which the increased bulk of the part is formed, yet that the working element, that which is the real agent, that which undergoes development, is not anything in the liquor sanguinis, but the living molecules of the affected tissue itself—that the nuclei and cells found in plastic material—say in granulations—are not developed in an exudation *simpliciter*, but are the fruits of the growth, multiplication, and proliferation of the pre-existing cells of the part in which they are found. "The connective tissue" says a most able expositor of this doctrine,* "is most extensively distributed through the body, so that an ever-present cell and nucleus containing texture is by it provided. Not only does it, in its various modifications, constitute many special structures, as tendons, ligaments, fascia, the cornea, vitreous body, Whartonian jelly of the umbilical cord, &c., but it enters into the formation of the skin mucous serous and synovial membranes, of muscles blood and lymph vessels, of nerve centres, and of nerves. It is found also in the glands

* Turner, W., M. B. Lond. The Present Aspect of the Doctrine of Cellular Pathology, Edinburgh, 1863. See Virchow's Cellular Pathology as based upon Physiological and Pathological Histology. Twenty Lectures, &c., by Rudolph Virchow, translated by Frank Chance, M.B., Cantab. London, 1860.

in considerable quantity, and serves as a sort of framework, in which the vessels and tubes and follicles, with their epithelial contents, are imbedded." According to this school, the cell-structures which characterize the so-called inflammatory exudations, the effusions in repair and in tumours, arise from the nuclei of the connective tissue and of other tissues, as tendon, cartilage, muscle, &c.

3. If the first set of doctrines may be called the "coagulable lymph pathology,"* and the second, the "cellular pathology," there is yet a third which may be called "germinal pathology." † This regards the mass of the animal body as composed of two sorts of substances—one the active living growing *formative*, or *germinal* material—the other, the *formed* matter, which has been elaborated by the vital agency of the first, and lasts a given time, forming the bulk of structures, and in the end decays, and is absorbed. The pulp of teeth, or rather the matter which fills the dentinal tubes, the nuclear matter in the laminæ of bone, and nuclei generally, are examples of the *germinal* material; the earthy matter of tooth and bone, the intercellular, or internuclear portions, are examples of the portions which are *formed* and have no inherent vital force. The germinal matter exists in masses corresponding usually with nuclei, but the existence of actual nuclei, or of cell forms, is not essential. Germinal matter can only be produced by germinal matter, and may exist in the blood and elsewhere in a state of division so minute as to be invisible by the highest glasses; it is the living, moving, formative element, distinguished after death by the ease with which it takes coloration by carmine; it attracts material from the blood, and converts it into tissue.

If, as the last doctrine assumes, "germinal material," *i. e.* living matter, may exist in the blood in a state of sub-division so minute as to be invisible to the highest microscopes, and to be able to transude the capillaries without rupture, there is little difference between the "lymph pathology" and the "germinal pathology" in accounting for the origin and nature of many diseases. For example, we may speak

a. Of local diseases—changes which originate in the minute living structures of some part, and are confined thereto, *e.g.* many tumours throughout their course; possibly some cancers in an early stage; simple, slight injuries, and the operations for their repair.

b. Local disease with constitutional disturbance;—extreme pain, produces great exhaustion, shivering, disturbance of the nervous system, and destruction of some part of the blood; moreover, fluids which have undergone change, and germinal or cell matter developed in a diseased part, may be received into the blood, and produce *sympathetic fever*.

c. Disease occasioned by *distant nervous disturbance*; as, for example,

* The doctrines of John Hunter, and the English school down to Paget; and of the Vienna and Edinburgh schools, Rokitansky, Hughes Bennett, Lebert.

† Dr. Lionel S. Beale. See an abstract of his Lectures delivered at the Royal College of Physicians in 1861, Medical Times and Gazette, 1861, vol. i. Also Beale's Archives, British Medical Journal, &c., 1863, *passim*.

local hyperæmia, or local deprivation of blood, occasioned by agents operating on the vaso-motor system of nerves.

d. Disease occasioned by blood disorder, (α) Blood disorder arising from common causes, cold, unwholesome food, &c., or disorder producing some peculiar morbid poison, as the gouty or rheumatic; which poisons are attracted to, and deposited in, particular tissues or organs, and there vex the living tissues and excite them to abnormal action. (β) Blood disorder arising from the presence of diseased germinal matter which has been absorbed from one part of the body, and may be exuded in another. Thus an unhealthy inflammation or a cancer may furnish germs which contaminate the blood, and constitute the material cause of secondary inflammation, deposits, or exudations. (γ) Similarly, diseased germinal matter, introduced from without, whether through the air passages or through a wound, may develop itself in the blood, and may constitute material for exudation; as in small-pox, and other zymotic diseases.

CHAPTER V.

GENERAL DOCTRINE OF REPAIR.

REPAIR NOT INFLAMMATION.—Since the animal body is liable to accidents, and the purposes of life could not be realised if every injury produced death or permanent disability, it is evident that a provision for repair, within certain limits, is as essential as that for daily nutrition. Within our own times, indeed, it has been customary to assume that all repair was an effect of inflammation. But a more precise pathology requires us to separate repair, a process beneficial, gentle, and painless, from inflammation, a process injurious, violent, and painful. True it is, that both repair and inflammation have the one feature, exudation, or rather cell-growth and consequent infiltration, in common; and that some cases of repair are more or less complicated by inflammation; and that in some others, as, for example, the case of hydrocele, or of a sinus, or of a non-united fracture, that an active inflammatory disturbance is set up, and that repair is effected by the cell-growth or exudations so induced. Yet it may be said of all repair that it is perfectly and rapidly executed in proportion as every symptom which can fairly be called inflammatory is absent.*

WHAT AMOUNT OF REPAIR IS POSSIBLE?—This is a question, like many others, of which a broad view cannot be obtained by attention to human anatomy and pathology alone. In some of the lowest animals, as

* On the subject of this chapter, the student should thoroughly master the chapters on Repair and Adhesion, in Hunter on the Blood; Travers on Inflammation, a work in which the venerable author treats of inflammation almost as the one disease, and as the agent of all repair; Macartney on Inflammation, which has laid the foundation for the modern reform of opinion; and the masterly summary of the whole subject in Paget's Lectures, 2nd edit. by Turner.

the polyp, repair seems to be almost unlimited, any portion of a severed animal being able to reproduce all the rest: whole limbs, too, are reproduced in the lobster and the lizard. But in the higher animals it is only the commonest structures that can be restored: for example, to quote from Mr. Paget:—

"1. Those which are formed entirely by nutritive repetition, such as the blood and the epithelia.

"2. Those which are of lowest organization and of lowest chemical character; as the gelatinous tissues, the cellular and tendinous, and the bones.

"3. Those which are inserted in other tissues, not as essential to their structure, but as accessories, as connecting or incorporating them with the other structures of vegetative or animal life; as nerve fibres, and blood-vessels.

"With these exceptions, injuries or losses in the human body are capable of no more than repair in its most limited sense—*i. e.* in the place of what is lost some lowly-organized tissue is formed, which fills up the breach and suffices for the maintenance of a less perfect life."

Seeing, then, that the *tissues capable of being reproduced*, are the connective or areolar tissue, including tendon and ligament, bone and cartilage, blood-vessel and nerves, and epithelium, but not more complex structures, such as muscle, we may next observe that

The most modern theory of the process is, that the germinal or living or nuclear elements in the injured tissue,—say bone or tendon—rapidly increase by imbibition of liquor sanguinis attracted from the blood, and by fissure and growth form a pale, fibrinous-looking mass; which, examined under the microscope, seems to be studded with nuclei at regular intervals, and undergoes conversion into fibrous tissue, cartilage, or bone. On the theory that the reparative material is an exudation of lymph in which nuclei form by inherent creative force, this material was called by Paget, *nucleated blastema*. This is the most perfect form of repair, and usually found in subcutaneous wounds.

In other cases the reparative material will be found to consist of large *nucleated cells*; which subsequently enlarge, elongate, split into the shapes known as *caudate*, *fusiform*, &c. Such cells imbibe water, under the microscope, which shows them to be separable into cell wall and cell contents, and the addition of acetic acid renders every part

* This cut represents, on the right of the page, fibro-plastic cells, of various sizes and degrees of development; on the left, cells which are developing into fibres; those at either end, marked × a, have been treated with acetic acid. Traced with the camera from actual specimens from granulations, healing wounds, and fibro-plastic tumours, magnified 200 diameters. The scale of ·001 inch will give an idea of the real magnitudes.

transparent and almost invisible, except the nucleus. At first their dimension is about $\frac{1}{500}$ of an inch. They are imbeded in more or less of a quasi fibrinous exudation, pellucid, or fibrillary.

These cells will often be spoken of in the following pages as *fibroplastic* cells. They are formed in abundance, in all the less perfect examples of repair. They are found as some of the commonest results of inflammation. They constitute granulations. They also constitute the basis of many tumours and morbid growth as the *fibroplastic*. They are liable to degenerate into pus. And when diseased or perverted they may be supposed to constitute the material of cancerous tumours.

But be it observed that although these cells are evolved under certain conditions out of the exudation which takes place during inflammation, yet that the absence of inflammation is essentially necessary before they can assume their full degree of development into tissue.

Blood organisable, yet not the ordinary material of repair.—In a less perfect state of knowledge it was supposed that the blood was the common medium of reparation. We now know that this is not the case; that effused blood is a hindrance rather than a help; that the clot which is effused from an injury is absorbed before the work of repair is perfect; and that if clots of blood be present in large quantity they are apt to decompose, and to cause suppuration. Yet it is quite true that thin clots of blood, under certain circumstances, are capable of undergoing a change into a fibrillated material similar to the unclotted blastema, and of receiving blood-vessels. Mr. Prescott Hewett showed, some time ago, that thin layers of blood effused into the cavity of the arachnoid may become vascular: it was also proved by Hunter, Macartney, Kiernan, and Dalrymple, that clots are capable of receiving blood-vessels.* Mere fibrinous deposits seem to form almost structureless membrane, inert and not vascular.

Formation of new vessels.—Twenty years ago, nothing was supposed to be organised which had not blood-vessels: and to *become vascular*, and *organised*, were used as convertible terms. Now, however, we know, as, in fact, what was known but not reflected on before, that blood-vessels play a subordinate part; and that organisation proceeds to a certain point before they appear on the stage: yet that they are necessary at a certain epoch, in order that the material for fresh growth may be brought within reach. The readiest way for the student to watch the formation of new vessels, will be to examine the lymph found on the edge of a placenta. There he may see the results of the process described by Paget, the budding out of branches from the nearest capillaries, which branches enter the developing lymph, and inosculate with each other, so as to form loops: from which, again, fresh loops are directly given off in like manner.

* Vide Palmer's ed. of Hunter, vol. iii.; Catalogue of the Hunterian Museum, vol. i.; Carswell, op. cit.; Macartney, op. cit. p. 51; Home, Phil. Trans. 1818; Wardrop on Aneurism, in the Cyclop. Pract. Surgery; Dalrymple, Med. Chir. Trans. vol. ix.; P. Hewett, *ibid.*, vol. x.; see also Lancet for 1845, vol. i. p. 219; Paget's Lectures, vol. i.

The time within which repair is effected varies as greatly as the nature of injuries and of constitutions. But vascularity, or propulsion of new blood-vessels into a new fibrinous exudation, may occur certainly in less than forty-eight hours, whilst in the progress of granulation, the growth of one day appears to become vascular by the next.

Conditions favourable for repair, and the reverse.—1. In the first place, *cæteris paribus*, the younger the system, the more capable is it of repair. 2ndly. The state of the blood may be so poor as not to yield the necessary material; or it may be so overloaded with ill-assimilated material, or so poisoned, that the new textures are ill capable of development, and run into degeneration. 3. *Local conditions* may be such as to afford mechanical or chemical complications. The reparative material if disturbed may perish, or if exposed to air or to poisonous influences, may undergo degeneration into pus, or into sanies which may infect the whole blood. In general terms, whatever favours inflammation is hostile to repair, and the converse.

Injuries with wound of skin, and without.—If we divide cases into two great categories—those attended with wound of skin, and those without, we find that the former are infinitely the more dangerous and difficult of repair: as evidenced by compound fracture and dislocation, and by wounds of the great visceral cavities, compared with the severest bruises and simple fractures. The reason of the difference is the fact, that reparative material exposed to the air and contact of the outer world is more liable to perish, and, having perished, to run into unwholesome changes, which may spread over the whole surface injured or exposed. It is a principle derived from this fact, that wounds of the skin are to be avoided when possible, and, when unavoidable, are to be as limited as possible: and that the *subcutaneous method* originally used for the division of tendons should be extended to every case admitting of it.*

CHAPTER VI.

INFLAMMATION.

SECTION I.—INTRODUCTORY.

DEFINITION.—A perfect definition of inflammation is at present impossible, forasmuch as we are ignorant of many of its conditions, and are not even agreed upon the processes which shall be included under the term. Perhaps we may say that it is "a diseased process, including hyperæmia, stagnation of blood, and exudation with disturbance of the minute structural or cell elements of the part affected."

SYMPTOMS.—The classical symptoms are four—pain, heat, redness,

* Sketch of Subcutaneous Surgery, by W. Adams, F.R.C.S. Lond. 1857. Refer to Tenotomy, False Cartilage, Bursæ, and Hernia.

and swelling; to which ought to be added, impaired function of the part inflamed. Besides, there is feverishness with every true acute inflammation.

SECTION II.—ANALYSIS OF LOCAL SYMPTOMS.

1. PAIN or *dis*-ease is sure to ensue when anything in the animal economy goes wrong, and the varieties it presents in inflammation require careful study. Thus (*a*) it may vary with the local cause which has produced it: thus patients talk of cutting, burning, stabbing pains. Every idiopathic inflammation also has its own kind of pain. Boil or carbuncle causes a different pain from that of phlegmon.

b. Then the pain will vary with the part inflamed; for each part has a set of sensations peculiar to itself; the bones and ligaments ache; the skin smarts or burns; an inflamed pleura, when stretched, feels as if torn or stabbed; the inflamed ear hears unnatural sounds.

c. Inflammatory pain is aggravated by preternatural irritability, or receptivity of impressions; thus *tenderness* is created:—unusual reflex actions also are excited by impressions conveyed to the spine, and *spasms* are excited, which are so painful a feature in conjunctivitis, croup, and dysentery.

d. The intensity of the hyperæmia causes the *throbbing* of the vessels to be painfully felt; particularly in inflammations of dense, unyielding parts, or of parts confined by fascia.

e. *Distension* by exudation causes intense pain in the like cases.

f. Pain may be felt at a distance, along the course of nerves irritated. Thus the testicles ache in irritation of the bladder. Similarly, pain may be felt along the course of lymphatic vessels and glands if they are impregnated by the inflammatory exudation.

g. Lastly, pain may be absent in slight cases. Moreover, it must be remembered that pain is a subjective symptom, and exists in the consciousness of the patient; and though the conditions for it exist, it may not be felt if the nerves are severed, or the brain stupefied by disease, alcohol, or narcotics.

2. The *heat* of inflammation is partly a *sensation*, and chiefly felt in inflammations of surfaces. Hunter believed that as an inflamed part receives more blood, so it is hotter than other parts; but yet not hotter than the mass of the blood. Thus supposing that the heat of the entire mass of blood be raised, the inflamed part, *if external*, will really be hotter than neighbouring parts, but not than the mass of the blood. On the other hand, Simon* has shown, by a delicate set of experiments, that the heat of venous blood proceeding from an inflamed part is greater than the heat of the arterial blood going to it: therefore that there is a source of heat in the part itself. This is probable, *à priori*, from the active processes carried on in it.

3. The *redness* is a consequence of the hyperæmia, and its appearance depends, in some degree, on the natural arrangement of the ves-

* Holmes' Surgery, vol. i.

sels of the part; thus, inflammation of the conjunctiva differs appearance from that of the sclerotic. But it is still more influenc by the cause of the inflammation: thus the vivid blush of phlegmo gradually fading into the natural hue, differs materially from t abrupt red, dusky patch of erysipelas. Moreover, the colour is oft modified by the blood or hæmatine exuded into the inflamed part, as boil and erythema nodosum; or by a peculiar condition of surface, in syphilitica lepra: so that almost every inflammation has its ow colour; and one—the phlegmasia alba dolens—is remarkable for havi no colour at all.

4. The *swelling* is caused first by the hyperæmia, then by ex growth and matters exuded into the inflamed tissue. It may be hard an brawny as in carbuncle, or soft, so as to allow the pressure of the finge to make a pit.

5. That inflammation must impair function is obvious. Motion i difficult or impossible; sensations exaggerated; secretion diminished and secreted liquids mixed with blood or serum, or fibrinous flakes.

SECTION III.—ANALYSIS OF CONSTITUTIONAL SYMPTOMS—TRAUMATIC, OR SYMPTOMATIC FEVER, OR FEVERISHNESS.

The word *fever* is now so wedded (although very improperly) to certain species, as typhoid and typhus, that perhaps it is better to use the word *pyrexia*, or *feverishness*, to express the sum of the constitutional symptoms attending acute inflammation.

The relation of the constitutional symptoms to the local may be one of these three:

1. The constitutional symptoms may precede and cause the local: as in common idiopathic inflammations, erysipelas, pleurisy, pneumonia, &c.

2. The constitutional symptoms may follow and be caused by the local; when the blood circulating through an injured part becomes contaminated by decaying animal matter, or by the irritation of the nerves; as in the case of acute inflammation following an ill-closed and irritating wound.

3. The constitutional having been caused by the local malady, may again be the cause of other local diseases elsewhere—as in pyæmia, and secondary suppurations.

Feverishness consists, as may be proved by experiment and by reason, (1.) in a change of the blood: (2.) in a series of operations for purifying the blood so changed;—by increased oxygenation—by increased secretion—and by exudation—or by all three.

Symptoms.—1. The first in order of time is *shivering*;—trembling of the muscles, sensation of cold, and, in severe cases, blueness, and shrinking of the features, and the other signs of abstraction of heat from the body. Its real nature is unknown: but the student will do well to regard *shivering* as a most important symptom at any stage of any disease, inasmuch as, to use Hunter's words, it surely indicates

"some new action set up in the blood." *Vomiting* is sometimes combined with it. Shivering is, as aforesaid, sometimes associated with actual intense coldness; sometimes, though the patient feel chilly to himself, his skin may be hot and burning. It seems to indicate a decomposition of the blood, or an admixture with it of foreign matter.

2. The *pulse* is raised to 100, 120, or more. In some cases it is hard and wiry; in others soft and jerking.

3. The *respiration* is also increased—to 25 or 30 in adults: in children to twice that number.

4. The *heat* is raised to 102—104 degrees; in some cases probably higher.

5. All the watery *secretions*—of skin, mouth, and urine—are suppressed. Food is loathed, but acids and water craved for.

6. *Headache*, wandering at night, and lassitude, testify to disorder of the nervous system.

7. The urine shows remarkable changes. Before an idiopathic inflammation it is often pale;—during the height it is usually scanty and high-coloured;—at the close, it is copious, and turbid with sediments of lithates. There are some exceptions to this, inasmuch as the increased excretion of lithate may begin before the disease, and cease earlier. During the height of acute inflammation, it is often albuminous—it contains serum from congestion of the kidneys, and tubular casts. Speaking generally, the uric acid, extractive matters, and specific gravity of urine are greatly increased during acute inflammation. The sulphates are at or above the usual average: the chlorides greatly diminished.

The *diminution of the chlorides* in the urine, which had long been known on the Continent, was made known in England, and the amount of fats greatly increased, by the researches of Dr. Lionel Beale, who has shown that every process of rapid development by cell growth in health or disease requires the presence of large amounts of chloride: (the ash of a fœtal thigh-bone, for example, contains much more per cent. than that of an adult); and that when any diseased process of exudation and cell growth is set up, the salt is withdrawn from the blood and urine, and is present in the infiltrated tissue.*

8. That the *state of the blood* is peculiar during acute inflammation is proved by the fact that when drawn its surface is almost immediately covered with a bluish layer, like size: whence inflammatory blood was formerly called *size*. So soon as the blood has coagulated, this layer is visible as a yellowish-white stratum on the surface of the red clot; and as it generally contracts so as to make the upper surface of the clot concave, the technical terms *buffed* and *cupped* have been applied to this kind of blood.

Various attempts have been made to explain these phenomena. For example: 1. Inflamed blood coagulates slowly; and it has been supposed that this accounts for the buffy coat, inasmuch as it gives

* Frinckel und Ravoth, Uroscopie, Berlin, 1850; Beale, Med. Chir. Trans. 1852; Simon, Animal Chemistry, vol. ii. p. 167.

the red particles time to sink and leave the upper surface of the clot colourless. 2. There is an *increased attraction* of the red particles for each other, so that they form themselves into a network of rouleaux, and sink with unusual rapidity: this is the view of Mr. Wharton Jones and Mr. Gulliver. 3. On Dr. Richardson's theory *ammonia* is the solvent of fibrine in blood, and the slow coagulation may depend on excess of the solvent, or on slow evolution thereof. 4. There is in inflammation an excess of fibrine in the blood; a state to which the name *hypermosis* has been given. 5. The white particles of the blood sometimes constitute a great part of the buffy coat.

The *chemical composition* of inflamed blood differs, according to Ancell, Simon, Becquerel, and Rodier, from that of healthy blood, in a diminution of the red particles and an increase of fibrine. Becquerel and Rodier state that in the *phlegmasiæ* the fibrine is increased invariably; that the increase begins with the beginning and lasts to the end, and is proportionate to the intensity of the inflammation; that it is present whether inflammation be the sole disease or be an accidental complication; that blood-letting does not lessen its over-proportion.

It must be remarked that the buffy coat is especially found in acute rheumatism, pleurisy, bronchitis, and pneumonia, and that it is found in most inflammations. But it is also found in erysipelas, puerperal phlebitis, phlegmasia dolens, tubercular phthisis, and in pregnancy. It is the normal condition in the horse. The proportion of fibrine may be increased from about 2·5, the normal proportion, to 5, 7, or 10 grains per 1000. In typhus fever, typhoid, and the exanthemata, an opposite state exists, called *hypinosis*.

Agreeing that the buffy coat is present in inflammation, the next question is, what is the connection? Animal chemistry has endeavoured to supply the answer to this question. It has been supposed that fibrine is a deutoxide or tritoxide of protein; that it is the product (as Becquerel and Rodier teach) of oxydation of albumen; or (according to Simon) of the blood corpuscles. It has been proved that the fibrine and blood corpuscles are generally in the inverse ratio, one of another; and that this is due to the quickened circulation and respiration, and increased oxidation and metamorphosis of the corpuscles.*

Virchow, however, altogether denies the "orthodox" doctrine of hyperinosis. Instead of believing that the change in the blood is primary and intrinsic, he believes it to "depend upon the local inflammation. Certain organs and tissues have inherent in them in a higher degree the power of producing fibrine, and of favouring the occurrence of large quantities of fibrine in the blood." There must also be

* See W. Hewson's Works, a medical classic that well deserves study; Sydenham Society, ed.; Wharton Jones, Guy's Hosp. Rep. vol. VII. N.S.; Richardson on Coagulation of Blood. Lond. 1858. Simon, op. cit.; Gulliver's Lectures on Blood, &c., Med. Times and Gaz., 1863, vol. II.; an admirable vindication of the English school.

means of introducing it into the blood. Thus the lungs and pleura, and other organs, largely supplied with lymphatics, introduce a large quantity of fibrine into the blood, when inflamed; whereas the brain, if inflamed, being poor in lymphatics, produces no hyperinosis. This state is usually attended with increase in the white corpuscles, which are products of the lymphatic glands and spleen. "There are," says Virchow, "three different conditions bordering one upon the other—hyperinosis, leucocytosis, and leuchæmia, between which and the lymphatic fluids there exists an intimate connection." Hyperinosis is to be referred to the accidental condition of the organs from which the lymphatic fluids are derived, whilst those states which depend on an increase in the cellular elements are rather regulated by the condition of the glands through which these fluids have flowed. Leucocytosis is an increase in the white cellular elements of the blood, depending on temporary or transient conditions of certain organs: leuchæmia, a permanent increase depending on fixed conditions, usually fatal. Leucocytosis to a certain degree takes place after every meal, from the matters which pass through the mesenteric glands. In pregnancy there is constant leucocytosis and hyperinosis, and enlargement of lumbar glands;—hence the buffy coat and the multitude of colourless cells in the blood, which have sometimes figured as evidence of puerperal pyæmia. In scrofulous enlargement of the lymphatic glands, the blood becomes loaded with white particles. So far Virchow.

SECTION IV.—ANATOMY OF AN INFLAMED PART.

An inflamed part has a large quantity of blood intruded into its vessels; and its tissues and their interstices are *infiltrated* with liquids which have exuded from, or have been attracted from those vessels. It is softer than a sound part, for the hardest tissues lose some of their cohesion. It is also redder, although mere redness, *post mortem*, is no proof of inflammation, for it may be produced by congestion or by a staining of tissues with dissolved blood pigment which has oozed out of the vessels in incipient putrefaction.

In its minutest analysis inflammation seems to begin with a kind of nutritive irritation,—an increased assumption of nutritive matter by the microscopic elements of the part, and a cloudy appearance, owing partly to the imbibition of unusual nutriment, partly to the enlargement of the germinal matter contained. The next step consists in fissure, multiplication and division of the nuclear and cell elements. Then comes hyperæmia,—of the part if it have vessels;—of the surrounding parts if it have none; and exudation, the appearance of liquor sanguinis, *i.e.* of serum and more or less fibrinous material, in the interstices of the part if it have interstices, or else into the neighbouring parts. Virchow divides inflammation

* Portion of muscle involved in inflammatory exudation; fatty degeneration of the muscle; and infiltration with fibro-plastic matter. From Nature.

into two forms—the *parenclymatous*, when the process runs its course in the interior of a tissue without our being able to detect the presence of any free fluid which has escaped from the blood; and the *exudative* or *secreting*, where an increased escape of fluid takes place from the blood. This belongs especially to surfaces—as serous, and especially mucous membranes.

Meanwhile, the newly-produced elements tend to degenerate into pus, whilst the proper elements of the tissue are starved and choked, and undergo fatty degeneration.

In the last generation, peculiar interest was attached to the condition of the blood-vessels, which were believed to be the seat and factors of inflammation. Although we see (or think we see) more deeply, it is as well to record the results of Paget and Wharton Jones's observations.

1. The primary effect of a slight stimulus applied to the blood-vessels, is a slight and temporary *contraction*, with a *retardation of* the current through them. If the point of a fine needle be drawn across a minute artery and vein three or four times, without injuring them or the membrane covering them, they will both presently gradually contract and close. This contraction is no doubt analogous to the speedy closure of the innumerable small vessels divided in a wound, which are made to contract by the very stimulus of the instrument which has divided them.

2. During this contraction, the blood moves more slowly, or perhaps does not move at all. But when the vessels dilate again, they acquire a larger size than they originally had, and the blood moves more freely and rapidly through them than it did before. And now the same stimulus that made them contract at first has no effect, or a very transient one; a more powerful stimulus, however, may make them again contract and close.

On applying a more powerful irritant, such as a drop of tincture of capsicum, the preliminary contraction, if it occur at all, is so transient as to be hardly perceptible, but the phenomena of *active congestion or determination of blood* become instantly developed. The blood-vessels become rapidly dilated, lengthened, and tortuous; sometimes even they display varicose or aneurismal excrescences; they are tensely filled with blood, containing a large excess of red globules, which is circulated with far greater velocity than is natural.

3. But if the injury inflicted be of still greater severity, as a wound with a red-hot needle, then in addition to the preceding state of active congestion, there follows, in the very focus of the morbid changes, a retardation, and, at last, a complete stagnation of the blood in the densely-crowded capillaries. "All round this focus," says Paget, "the vessels are as full, or nearly as full, as they are in it; but the blood moves in them with a quicker stream, or may pulsate in the arteries, and oscillate in the veins; yet farther from this focus the blood moves rapidly through turgid but less full vessels." The dusky colour in the centre of a phlegmon; the throbbing; the red blush around; the gush of blood on cutting into it, are thus fully explained.

SECTION V.—PROGRESS AND TERMINATIONS.

Inflammation, once established, may destroy life, either by impeding the functions of some organ necessary to life, as the heart, lungs, or brain; or by quick exhaustion or syncope, as in inflammation of the abdominal organs; or by slower exhaustion, from suppuration.

Or it may end in complete subsidence (*resolution*, as it is technically called) and recovery, provided that the blood be purified, and that the changes which have been effected in the cell elements of a solid part, are confined to absorption or swelling, and have not gone on to the production of matters which must perish or suppurate; and that local irritation be done away with. Then sleep, appetite, and moisture of the skin return; the pulse becomes natural and the urine deposits a copious brick-dust or *lateritious* sediment of lithate.

Besides death, and recovery, it is customary to treat of certain palpable effects, or as they used to be called, *terminations* of inflammation. These are, 1st, *Hæmorrhage*, from the rupture of over-distended capillaries; 2nd, Serous exudation; 3rd, Fibrinous exudation, constituting the so-called *adhesive* inflammation; 4th, Suppuration; 5th, The destruction of the affected tissues in detail or in mass; varying from the softening and absorption of caries, or the fatty degeneration of white softening of the brain, or the slow erosion of an ulcer to the gangrene of an entire member. According to Hunter, these different effects were produced by differences in the intensity of inflammation, which were supposed to decrease as the distance from the centre increases. Thus at the outskirts of an inflamed part there will be a ring of serous effusion or œdema: within this a solid layer of fibrine, which forms a sac, within which is pus, formed by the softening of the central fibrine. If to the *serous effusion*, *adhesion*, and *suppuration*, thus present, we add *hæmorrhage*, and *gangrene* or the death of some of the tissues involved, and *ulceration*, or a process of disintegration by which pus is discharged, we have the six *terminations* of inflammation; although, be it observed, every one of them singly may occur quite independently of inflammation.

SECTION VI.—CAUSES AND VARIETIES OF INFLAMMATION.

The cause of inflammation may be anything which disturbs the ordinary nutrition, function, or growth of a part.

1. *Local causes.*—The most effective is *over-exertion*; the compelling a part to go through the processes of wear and tear, and demanding of it an amount of repair beyond its powers. Alternations of *heat and cold*, which disturb the chemical changes going on between the blood and the tissues; *injuries* of every sort, mechanical and chemical, especially such injuries as leave a part half-killed, or in which the processes of repair are interfered with, so that the new cell-formations and exudations are killed, and left to decompose; poisons of all sorts, especially septic poisons, which communicate a state of decom-

nerves. But it is clear that divis
sense or *motion per se*, has no r
mation. Wounds of paralyzed pa
inflammations of paralyzed parts
mere paralysis; for instance, a
presence of foreign particles, and
division or paralysis of *vaso-moto*
capillaries and profuse circulation
cervico-cephalic branch of the symp
and side of the face become hot, red,
Bernard, if the animal be starved,
junctiva and pituitary membrane ru
being defective, absorbs greedily fro
Some injuries produce reflex irritation
of blood. This has been given by Bro
ulceration of the duodenum which fol
are some nerves which if irritated co
the supply of blood, and thus may cau

3. *Constitutional causes.*—The bloo
or overcharged with material prone
action of the excreting glands be chec
seem to fly to some organ and excite
deficient in quantity and quality. Fo
from exuberance of blood, there are
which arise from poverty. It may b
can be admitted into the blood seem
which it vexes, and through whic
the bowels and mouth; aloes, the rect
the air passages; turpentine, the kid
blood-poison has its special seat for a
those of zymotic and organic origin,
scarlatina, syphilis, and the like

Bright's disease. *Cold* is a frequent cause of inflammation. It checks the secretion of the skin and deranges the chemical actions going on in the blood. The organs which first receive the chilled blood, viz., the lungs, are the first to suffer, then the gelatinous tissues, bones, joints, &c., as in rheumatism. *Grief* and *anxiety of mind* impoverish the blood and poison it with effete matter. Lastly, *embolism*, the transplantation of venous clots, or of concretions from the heart. Clots from the veins, after parturition or severe injury, or clots which form in limbs œdematous and motionless as in phthisis, may find their way to the heart, and if not large enough to block up the pulmonary artery will be carried into the lung and create disease. The fact that the lungs receive venous blood, which may be chilled or mixed with putrescent matters from a wound, renders it wonderful that they do not inflame oftener than they do. There is the term *metastasis* employed to signify, not the successive participation of several organs in one general inflammatory attack, as in rheumatism, but the cessation of inflammation in one part, and its transference to another; as, when in gout, pain in the heart or stomach ceases if the great toe become inflamed.

SECTION VI.—CAUSES AND VARIETIES OF INFLAMMATION.

The VARIETIES of inflammation depend on the cause, and on the kind of constitution conjointly. Thus we read of

Sthenic, or active inflammation, which is the disease as it affects a vigorous person.

Asthenic, or *low*, or *weak*, which is the disease of a weak, asthenic person: or which may be produced by certain causes of a lowering nature, as hospital air, and other poisons. It is more obstinate and less amenable to treatment than the active or sthenic.

Common inflammation is that which may be produced by ordinary causes in most individuals.

Specific inflammation requires a specific set of causes, chiefly animal poisons, or a peculiar state of blood, and cannot be produced at will.

The chief specific inflammations are gout, rheumatism, syphilis, scrofula, diphtherite, erysipelas, phlegmasia dolens, glanders; boil and carbuncle; erythema nodosum, eczema, lepra, and most skin diseases. It must be laid down as an axiom that every different cause produces its own specific set of consequences. This point is very clearly stated by Dr. Budd.* Take inflammation of the knee-joint for an example. If caused by a penetrating wound, with admission of air, rapid suppuration and destruction of the joint usually follow. If caused by the presence of pus or decaying fibrine in the blood, there will be little swelling, but suppuration so rapid as to encourage the belief that the pus, instead of being formed in the joint, is brought there. If caused by rheumatism, there is severe pain, and much effusion; but that effused fluid is never purulent, and is almost always absorbed as the patient recovers. If of gouty origin, there is more pain and considerable effusion, which

* On Diseases of the Liver, 2nd ed. Lond. 1852, p. 65.

is apt to leave particles of lithate of soda behind in the synovial membrane, and in the areolar tissue around. If a consequence of gonorrhœa, there is abundant effusion, and great swelling, very difficult to get rid of.

Sthenic inflammation is generally *circumscribed*, and most intense at one central point. Asthenic inflammation, especially from poisons, is often *diffused*, *i. e.* wide-spread, with no efficient boundary to the softened exudations.

There are yet some other classifications of inflammation with which the student ought to be familiar; for example: *Acute* inflammation is that which runs through its course quickly; *subacute* is a mitigated acute inflammation; *chronic* is less violent, and tends to last indefinitely.

We read also of œdematous, adhesive, hæmorrhagic, ulcerative, and gangrenous inflammation, according as the disease tends to produce either of those effects respectively.

Lastly, in the pathology of thirty years ago, it was customary to suppose that the effects of inflammation depend on the part affected; thus we heard of mucous, serous, and fibrous inflammation; and much was made of an alleged final cause, in the fact that mucous membranes generally suppurate if inflamed, and that serous membranes generally adhere by lymph. This is true; but it is not true that the exudation of lymph from mucous surfaces is impossible or rare, although the rapid production of fresh layers of epithelium or pus tends to cast it off and prevent it from becoming organised; and thus the obstruction of mucous canals is prevented.

SECTION VII.—THEORY OF INFLAMMATION.

Physicians have in all ages wished for such an intelligible conception of the process as would enable them to connect it with the other classes of facts of which they have scientific knowledge. But it is quite certain that we can have no clear conception of disease till we understand health; and that all the theories of inflammation that have been framed are preconceptions in the mind of the theorizer, who merely applies to the phenomena such philosophy as he may chance to have. Whatever notions about science in general, or physiology in particular, occupy the mind at any given time, are sure to be applied to the explanation of inflammation. Thus in the time of the ancients, when the arteries were believed to hold air, it passed for a decent theory of inflammation to assume that blood had found its way into them, as Celsus narrates. In the earlier humoral pathology, ill-humours of various sorts were supposed to fall upon the organs affected. The words defluxion, gout, and catarrh, are relics of this theory. Mathematical physicians of the school of Mead supposed the vessels obstructed by aberrant particles whose size and shape would not allow them to pass. Hunter and his school spoke of inflammation as *excited* action of blood-vessels. The earliest microscopists of the

present century, Wilson Philip and Hastings, saw in the dilated and gorged vessels nothing but relaxation, debility, and want of action. Whilst the doctrine of action of blood-vessels was prevalent, Gendrin, Mayo, and others showed elaborately how the successive stages of inflammation were so many mechanical consequences of different degrees of obstruction or relaxation of blood-vessels. The school of Liebig saw in it increased oxydation. The explorer of the blood sees in it the results of hyperinosis, or other changes in that liquid. The modern microscopic physiologist sees abnormal conditions of nutrition and of attraction between the blood and tissues; the believer in cells, as the agents in health and disease, sees in inflammation a perverted growth and proliferation of cells. The most advanced physiologist of the day, who has discarded a mere doctrine of *cells*, and sees in the living body the work of germinal material, refers the phenomena of inflammation to exaggerated growth of that material.

Then it must be noticed, that the search for a theory has been like the search for the philosopher's stone, or for the Grand Arcanum; when found it was to be a key to all difficulties, and to show, *à priori*, the right plan of treatment. He who believed increased vital action to be the essence of inflammation, of course drained the blood-vessels, starved the stomach, and used every poison capable of "lowering the heart's action." He who saw debility in the distended vessels proposed stimulants. He who sees oxygenation of the blood, proposes remedies calculated to diminish oxydation. One theorist proposes remedies that shall hold fibrine in solution; another those which shall check the growth of germinal material, and so on.

But each of these suppositions may be true to a certain extent: there may be increased action of the arteries, debility of the capillaries, increased oxygenation of the blood, and perversion of nutrition; but yet these are but accidents and accompaniments of a process whereof we are not able to grasp the essence. HE only who knows and sees all things can frame a perfect theory.

SECTION VIII.—ACUTE INFLAMMATION.

DEFINITION.—Acute inflammation is that which is sudden in its origin, violent in its action, and rapid in producing some one of the so-called effects of inflammation; and it is attended with fever.

The surgeon should always estimate the natural tendencies of the particular kind of inflammation, the cause that it depends on, and the organ which it affects. Because there are many inflammations which run a certain course, and then get well of themselves; others in which every effort must be made to relieve an organ whose integrity may be essential to life.

TREATMENT.—Generally speaking we should say that the indications are, 1. To remove the cause. 2. To purify the blood. 3. To soothe the disturbance of vitality and sensibility in the injured part.

4. *To moderate the afflux of blood.* 5. *To hinder degeneration in the fluids exuded, and procure their absorption.*

We shall speak in this order of the means by which each indication may be fulfilled.

1. *To remove causes.*—The taking away of any irritating substance, such as thorns and splinters, and placing every injured part under such conditions that the reparative exudations shall not be disturbed, are so obviously necessary as to require no mention.

2. *To purify the blood.*—In most cases, and more especially if the complexion is muddy, the bowels confined, the tongue foul, the urine either loaded or preternaturally pale, a dose of from one to five grains of calomel may be given, and followed by black draught, castor oil, colocynth, or some other purgative, and repeated so long as the stools continue lumpy, dark, bilious, and offensive, or until they are inodorous. In gouty cases, the acetic extract of colchicum may be combined with the calomel. See F. 33, et seq.

Both the kidneys and skin may most usefully be made to perform their functions by warm baths; by cold drinks, saline, and alkaline draughts, F. 58, lemon-juice, seltzer-water; by small doses of antimony, or of colchicum, F. 68, 69, &c.

3. *To allay the irritation of the affected part.*—This is a most important indication in the prevention and treatment of inflammation. All pain and sense of injury should be tranquillized if possible. For this purpose, in most cases, warm fomentations are advisable, particularly if medicated with decoction or extract of poppies, F. 121.

Warm fomentations relax the skin, soothe pain, and promote perspiration, and likewise hasten suppuration when that is inevitable. They are especially indicated in inflammations of dense tendinous parts. But in every case the patient's feeling should be consulted, and the application be warm or cold according to his choice.

Injured or inflamed parts should be kept at rest, in an easy position, and should be elevated slightly, so that the return of blood may not be hindered.

To fulfil this indication, *opium* and other anodynes are of the greatest value. They should be given after injuries and operations, in such quantities as to keep the mind tranquil, and prevent the patient from concentrating his whole thoughts upon the part affected. They tend to diffuse the blood generally, to warm the skin, and to prevent local congestion, and they save the exhaustion of pain and spasm. In most cases of acute idiopathic inflammation it will be expedient, before administering opiates, to take care that the blood is well purified; and whenever bleeding is necessary, that also should be executed first of all. But in inflammation of the bowels, in which repose is essential, in *low* inflammation arising from morbid poisons, or in exceedingly debilitated or exhausted states, with a soft, rapid pulse, and when the patient is sleepless and harassed in mind it is of infinite service, and may be given at once. Henbane, hemlock, and the extracts of aconite and belladonna, are likewise of great use in many cases as anodynes,

and though they have not the soporific virtues of opium, yet neither do they lock up the bowels. Vide F. 30, 32.

4. *To moderate the afflux of blood.*—Since the determination of a large current of blood to the affected part, and its stagnation therein, are leading phenomena in acute inflammation, it cannot be wondered at that means for controlling this afflux are of the very highest consequence. First amongst these stands—

Bloodletting.—A measure life-giving in its proper use, and deadly if abused. Its benefits may be explained on any theory. By diminishing the mass of blood, it lessens the labour of the heart and lungs, and allows the remaining blood to be oxygenated and purified by natural influences. It is most particularly indicated, as Dr. Markham has shown, in inflammations complicated with difficulty of breathing, such as pleurisy, fractured rib, &c. It diminishes the rush of blood to the inflamed part, and allows distended venous capillaries to empty themselves. It decreases the specific gravity and increases the absorptive power of the blood; it promotes the action of the skin and bowels; it imitates the spontaneous hæmorrhage by which nature often gives great relief; and it produces a most delicious sense of languor and repose, like that of the Turkish bath.

Manner of Bleeding.—General bleeding should be executed in such a way as to cause slight faintness as quickly as possible. For this purpose the blood should be drawn as quickly as possible, from a large orifice; and, above all, the patient should sit or stand upright. For if the blood is drawn slowly, so that the vessels have time to adapt themselves to their diminished contents, or if the patient is lying down, so as to assist the flow of blood to the brain, the bleeding may be continued almost to death without the occurrence of faintness.

Quantity to be taken.—As a general rule, the blood should be permitted to flow till paleness of the lips, lividity about the eyes, sighing, nausea, fluttering pulse, and relief of the pain, indicate the *approach* of faintness; but *full* faintness should always be avoided.

The quantity required to produce this effect, on a healthy adult, was ascertained by Marshall Hall to be about 15 oz.; but in robust adults affected with acute inflammatory or congestive attacks of the head or viscera, a greater quantity may be taken.

The class of patients whom it is allowable to bleed, as a general rule, are the robust with red lips, firm muscles, rustic open-air occupations, firm pulse, and rigid fibre. Pregnant women usually bear bleeding well. If the lips and conjunctiva are pale, showing deficiency of blood; if the patient is bulky, soft, and flabby; if there is any weakness or degeneration of heart; or if there is any continuous disease of assimilation—scrofula, Bright's disease, or the like—bleeding can scarcely be thought of.

The class of inflammations in which bleeding is permissible are those of sthenic inflammation of vital organs, especially the chest. It is not allowable, as a rule, in the *hypinotic class* of maladies, nor in erysipelatous diseases; nor in the case of injuries requiring great

constitutional efforts for their reparation, as compound fractures; if the disease be advanced towards suppuration or gangrene; and seldom indeed in the case of any zymotic disease, or inflamm having a natural tendency to recovery.

Local Bloodletting.—Whilst it must be admitted that in a generation general bloodletting was carried to an injurious exce the present day it is to be feared that local bloodletting is too n neglected. It is a most obvious, rational, and mild process; a imitates and seconds the efforts of nature by removing some of blood which may be assumed to be impure, and by taking it from part where it is in excess.

The *local means of abstracting blood* are leeches, cupping, and s fications. In order to apply leeches, the part should first be was and if they will not stick, a little milk or blood should be smeare it, or some small punctures should be made with the point of a lan and the leeches should be well dried in a cloth. The best pla stopping hæmorrhage from leech-bites is to dip small pellets of lin tinct. ferri sesquichloridi, or powdered alum, and press them on holes for a few minutes. Other plans are to touch them with a hot knitting-needle, or to stitch them up with a very fine needle silk, or to apply a small piece of *matico* leaf. But in order to vent dangerous bleeding, directions should always be given that leech-bites should be stopped before any patient is left for the nig Moreover, it will be prudent to apply them over some bone, so t pressure may be applied effectually. Again, leeches, if they stick long, should be removed by touching them with salt, and should not pulled off forcibly; nor should they be applied to the eyelids or p puce, otherwise they will probably be followed by œdematous swe ing. *Cupping*, when it can be adopted, is a more active measure, a relieves pain sooner than leeches. *Punctures* are of use in superfic inflammations of the skin; *incisions* are of use when inflamed pa are covered with a dense unyielding fascia, as in whitlow; or wh there is great tension, as in phlegmonous erysipelas; or when the flamed part is infiltrated with an irritating fluid, as in extravasation urine, or with unhealthy matter, as in carbuncle.

Cold is a valuable means of diminishing afflux of blood, a morbid heat. It may be applied by *evaporation* by means of single piece of thin linen frequently changed and dipped into cold wa or *evaporating lotion* (F. 115); and care should be taken that t vapour may pass off freely, otherwise the cold lotion will soon be co verted into a hot fomentation. Or *dry cold* may be applied by mea of bladders filled with water, ice, or frigorific mixtures. It must b observed that dry cold applications are less irritating than wet; a india-rubber bags, or glass or metal bottles, less so than bladders. Th surgeon must use his discretion as to the degree of cold. The poss bility of causing sloughing must not be forgotten either.* Or b irrigation, as recommended by Dr. Macartney. The inflamed limb i

* See Esmarch's Essay on the Use of Cold in Surgery. Syden. Soc.

to be placed in a trough or piece of oilcloth, with a piece of lint on the inflamed part. A large vessel of cold water being then placed on a table by the bedside, one end of a broad strip of cloth should be dipped in the water, and the other end (which should be cut to a point) laid on the lint; and so the water will be carried in a constant gentle stream down to the inflamed part. Cold is well adapted to inflammations of the head, and of the skin *or* external parts: but if it should not be *agreeable to the patient*, tepid or warm applications should be substituted.

5. *To control changes in the exuded fluids and new cell growth.*—There are some remedies which are believed to have the power either of destroying or removing that element in the blood which is the cause of disease, or else of so acting upon the morbid effusions as to cause their dispersion and absorption. *Mercury* is the chief remedy of this class; and the popular doctrine is, that, in acute inflammation, especially of serous or parenchymatous structures, mercury causes absorption of lymph, or of the effused fluids; and that for this purpose it should be administered in repeated doses, with sufficient opium to prevent it from running off by the bowels, and that it should be continued till the mouth is affected. F. 62—67 will show the common mode of administration.

This plan of giving mercury crept in at the beginning of the present century. One of the earliest notices of it is given by Sir J. M'Grigor, who considered it as much a cure for hepatitis as for syphilis. It was also largely used in tropical dysentery, and was given unsparingly till the patient was salivated.* Indian practitioners abused it largely.

The author believes that the absorbefacient and antiphlogistic virtues of mercury have been grossly exaggerated, except in the case of syphilitic inflammation of the eyeball. All salivation is a cruelty and a mischief. The author has seen low pneumonia arise in a case where the system was thoroughly impregnated with mercury. Hence it is no antidote. The truth seems to be: 1st. That much of the benefit arising from "calomel and opium" is due to the opium. 2ndly. That the calomel does good to some extent, as an eliminative. 3rdly. That mercury possesses some absorbent or rectifying virtue, in lingering inflammations; but that very small doses suffice. F. 63.

In the case of children, calomel should be given in continuous doses, till it causes green, chopped-spinach-like stools.

Tartar emetic may be used either in nauseating doses, F. 68, to depress the heart's action and cause perspiration, or else in emetic doses, to purify the blood by vomit and stool and promote expectoration; or it may be combined with purgatives, of which it greatly increases the action, F. 40, or with mercury, F. 62, or lastly, as a direct antiphlogistic, after the manner invented by Marryatt, and detailed under F. 68 in the Appendix. Antimony, like bleeding, is best adapted for the early stage of inflammation, before effusion has occurred.

* Sir J. M'Grigor's Medical Sketches, Lond. 1804, p. 174. Dr. Farre, Sen. Theory of the Action of Mercury, in Dr. Ferguson's Essay on Puerperal Fever.

The *carbonate of ammonia* is, in the writer's opinion, a speci severe forms of low inflammation; as bronchitis and rheumatism, Other remedies there are, as veratrum viride, aconite, &c., repu possess antiphlogistic virtues; but the writer has neither faith knowledge thereof.

Counter-irritants.—Blisters are the best form of counter-irritant recent inflammation; but they should never be applied too near the of an acute disease, and never till its activity has been subdued previous antiphlogistic measures.

Diet.—There is nothing in inflammation which betokens inc of vital power. Increase of *action* is one thing; but it no more im increase of power than lavish expenditure of money implies increas income. There is therefore no reason why a patient should be star merely because he may have an acute inflammation. Yet there some cases in which *low diet* is essential; for instance, at the be ning of acute idiopathic inflammations of internal organs in yo robust persons who have been over-indulging in meat and beer. should comprise abundance of *water*, especially with lemon-juice, alkali in effervescence, or Seltzer- or soda-water, or saline draugh which need not taste of physic;—besides tea, with milk, gruel, bre &c. But in sthenic cases so soon as the tongue permits, and in m cases from the beginning, a *middle diet* may be allowed, compris beef-tea, or other broth, light milky puddings, vegetables, &c. Whi in cases of debility, from the first, good beef-tea and wine must allowed freely, and in all others if the pulse becomes soft and fas and the cheeks, or hands, or feet chilly.

Regimen.—There must be a total avoidance of everything that wou irritate mind or body. Perfect rest in the recumbent posture, and a position as easy as it can be made,—cool air,—a quiet and darkene chamber,—with mental consolation, to allay doubts and fears and in spire resignation and cheerfulness, are most potent aids to medica treatment, which without them would often be utterly fruitless.

SECTION IX.—CHRONIC INFLAMMATION.

Definition.—Inflammation is said to be chronic when it is slow in its progress, and tends to last long, or even indefinitely.

Pathology.—It consists in permanent local hyperæmia, with exudation into the interstices of the part affected, or from its surface; if that be a mucous membrane, the secretion is probably purulent.

Causes.—Its causes may be local or constitutional. Thus it may in the healthiest subjects be caused by any slight and continued irritant; —or it may be the sequel of acute inflammation. But more frequently it is the local manifestation of some constitutional disorder, such as general debility,—or over-stimulation and plethora,—or disorder of some important organ, as of the stomach, or liver, or kidney,—and consequent impurity of the blood.

Treatment.—The indications are, to remove all constitutional dis-

order, to allay local irritation, and to restore the tone of the distended vessels.

Constitutional Treatment.—On this part of the subject, our space forbids us to do more than to make a few remarks on the most obvious forms of constitutional derangement which accompany chronic inflammation, and on the remedies that are known by experience to be most useful as alteratives.

(1.) If the patient is bloated and plethoric, with red lips and conjunctiva, and a full hard pulse, and indulges freely in stimulating food and drink, and has active digestive organs, so that blood is constantly formed in too great abundance, the diet must be lowered and restricted chiefly to fish and vegetables; free exercise should be taken in the air; the bowels should be actively purged with calomel and black draught; and then a course of alterative medicine should be commenced in order to increase the various eliminative secretions. Mercury, given in small doses at bed-time with saline aperients in the morning, deserves to be mentioned first: Plummer's pill, in doses of gr. v. every night, is an excellent form, or F. 63, 65; taking care, however, to use the mercury in obtaining increased elimination by the liver, and not to cause salivation. Next to mercury, tartar emetic, given in very small doses, F. 68, is deserving of notice; it is highly advantageous to combine it with mercury, F. 67. Saline and alterative medicines, F. 58, 61, will also be of great service.

(2.) But if the chronic inflammation occur in an enfeebled and irritable or scrofulous constitution, a nutritious and liberal diet must be adopted, wine, cod-liver oil, and tonics (F. I, 2, 3, 9, &c.) should be administered in order to improve the digestion and vigour of the circulation; irritation and pain must be allayed by sedatives and opiates; and the secretions of the bowels be maintained by the gentlest laxatives.

(3.) If the complexion and eye are sallow, a few doses of calomel or blue pill, at night, or F. 63, with morning aperients, and the nitro-muriatic acid, F. 22, or dandelion, and colchicum, are indicated.

(4.) In all cases the condition of the urine should be inspected, to ascertain whether albumen or blood discs,—indications of congestion or degeneration of the kidneys,—are present. In such cases, and in all others in which the skin is dry and harsh, it should be stimulated by exercise, by warm clothing, especially flannel, by the flesh-brush or horse-hair gloves, and by a daily warm bath; 96°—98° Fahr.

Local Treatment.—This has for its objects, to remove exciting causes, to unload the distended vessels, and to make them contract to their natural calibre, and to exercise the part in its proper functions, so that it may gradually resume the actions and sensations of health.

Local bleeding may be employed at intervals to unload the vessels. The application of cold is often highly serviceable. These or any other measures will be known to do good if they make the part feel stronger and more comfortable, although their first application may have been painful; but if they render it hotter and permanently

painful, it is a sign that they stimulate too highly, and may thus bring on an attack of acute inflammation. If it be a mucous membrane, stimulating and astringent remedies may be tried.

Counter-irritants are more useful in chronic inflammation than in the acute, especially those which establish a permanent suppurative discharge.

SECTION X.—MODIFIED INFLAMMATION.

I. In the two sections foregoing, we have described the treatment of inflammation in general. Many of the modifications have been enumerated at p. 35, and will be found by reference to the Index. Here we may allude shortly to

II. OUTWARD CAUSES OF MODIFIED INFLAMMATION.—We also showed, at p. 33, that some of the causes of inflammation are outward, and that others reside in the patients themselves. Of the outward causes, those which interest the surgeon will be discussed in the next part of our work; in which there will be described the various modifications of inflammation ensuing on cuts, blows, gun-shot wounds, heat, cold, and poisons of various kinds.

III. INWARD CAUSES.—The inward causes consist in morbid states of the patient's blood. Under the head of scrofula and carbuncle will be noticed some of the modifications of inflammation arising in this way. It may not be out of place here to notice one or two others.

1. *Gout.*—It is out of our province to describe gout, yet, amongst the maladies commonly called surgical, are many distinctly gouty; such as severe inflammations of the eye and of the testis, severe eruptions of the skin, and irritable states of the kidneys, bladder, and urethra. The chief marks that any acute or chronic attack is of a gouty nature are, that it probably arises quite suddenly; yet that the patient, if cross-questioned, admits that he has not been quite well for some time; that possibly an aching in the great toe, or spot of psoriasis on the skin, or that some very anomalous symptom, cough, dyspepsia, or hypochondriasis, has existed for some time, and has gone off just before some more important part has suffered. The patient is probably either too florid, and has been living too well, thus producing what the writer calls *high gout*, or, on the contrary, has been exhausted by fatigue or anxiety, thus producing what we call *low gout*. The bowels are probably torpid; the urine either very pale and copious, or scanty and full of lithates: gout probably also exists in the patient's family. The treatment of an acute attack will consist in active purgation, with calomel, colchicum, and alkaline aperients, F. 61, 71, with warm baths, low diet, and saline draughts. In a chronic attack, the more cautious use of the same means, followed by bitter infusions with alkalis, and alteratives, F. 72. Intense pain, and utter loss of function, followed by complete recovery, are characteristics of gouty inflammation.

2. *Rheumatic Inflammation.*—This, if acute, may usually be known by the intense aching aggravated by warmth, the profuse per-

[redacted] and the tendency of the malady to shift from one tendinous or muscular part to another. If chronic, there is an obstinate aching, sometimes worse at night, sometimes relieved by the warmth of bed. For the acute, moderate purgatives and alkalis, F. 65, 70; for the chronic, vapour-baths, warm aperients and stimulants, F. 7, 38, are indicated; and, in most sub-acute affections, the iodide of potassium, F. 94. 96.

3. There are many modified chronic inflammations, such as those which give rise to eczema, psoriasis, &c., difficult to describe or classify, yet easily recognised in practice, which evidently depend each on a particular blood-taint, and each of which is benefited by some special alterative. In all cases it is right to begin with *general* treatment; that is, to improve the health, to see that the bowels, kidneys, and skin do their duty, and that the diet is sufficient. Then, if general treatment does not avail, some specific remedy must be sought. First, we may mention, *iodide of potassium*, which has the power of dissolving many old deposits in rheumatic, gouty, scrofulous, and syphilitic cases, and of improving many skin eruptions, F. 94. Secondly, the *liquor potassæ*, F. 78, which, as Dr. Parkes has shown, undoubtedly causes oxidation of some blood elements. It is indicated when the urine is red, and contraindicated in most cases of mere debility. Besides these alteratives, we must mention sarsaparilla, small doses of corrosive sublimate in tincture of bark, F. 87, and arsenic, F. 97, which are also useful in certain chronic inflammations, especially of the skin. In many of these the real evil seems to be a want of vigour, through which the tissues in question seem unable to maintain their vitality. It is on this principle that mineral tonics, as arsenic, zinc, copper, and the mineral acids seem to do good, by giving a better quality to the materials assimilated.

CHAPTER VII.

EFFUSION OF SERUM AND ŒDEMA.

EFFUSION OF SERUM may be caused, 1st, by any circumstance which hinders the return of venous blood; this is called *simple œdema*. 2ndly. It may be caused by a depraved state of the blood, arising from disease of the kidneys,—*renal dropsy*. 3rdly. It may be an inflammatory exudation.

In almost all cases of inflammation, effusion of serum is the earliest and most constant effect; the liquid being poured out equally into the areolar tissue—into the parenchyma of organs—from mucous and serous surfaces, and from the skin. If it is followed by any of the other effects of inflammation, it is always more widely extended than they are. But it may be the chief or only effect of inflammation, as in œdema

[redacted]
SAN FRANCISCO, CAL.
and is not to be removed from the

glottidis, and the so-called acute hydrocephalus; and some subacute inflammations of the serous membranes. In patients of a lax, flabby habit of body, and in parts of loose and cellular structure, as the prepuce, eyelids, and scrotum, inflammation always produces more of this effect than in those of a firmer texture.

The serous liquid effused in consequence of inflammation is, as Mr. Paget observes, not the merely albuminous liquid which is commonly known by that name, and which is exuded in passive dropsy, but is in reality liquor sanguinis, and contains a variable quantity of fibrine; as may be readily proved by the spontaneous coagulation which takes place in the so-called serum exhaled from the skin under a blister of cantharides. It is difficult to explain why the effusion remains within the body, as it may for many days and even weeks, without the fibrine separating and becoming solid.

The so-called inflammatory serous effusion may terminate in four ways:—1st. It usually becomes quickly absorbed; an event which is hastened by such purgatives and diuretics and tonics as tend to drain the blood of impure materials, and give vigour to the circulation, and by bandages and other means of local stimulation. 2ndly. In some cases it resists absorption for a long period, or altogether; of which hydrocele, some cases of hydrothorax, hydrarthus, and hydrocephalus, afford examples. 3rdly. The fibrine may slowly separate from the serum, and solidify, causing a doughy indolent thickening of the cellular tissue, the treatment of which will be mentioned at the end of the ninth chapter. 4thly. The serum effused may distend the cellular tissue, so as to interfere with the nutrition of the skin; which may be remedied by making punctures with a needle, and allowing it to ooze gradually out. Of the manner in which serous effusion may prove fatal to life, in the œdema glottidis and hydrocephalus, it is not our purport to speak at present.

ŒDEMA is the name given to the swelling caused by the presence of serum, whether inflammatory or dropsical, in the cellular tissue. It is a soft, inelastic, diffused swelling, which *pits on pressure*, that is, retains for a time the pit or mark made by the pressure of the finger. If œdematous limbs become inflamed from any cause, the skin is exceedingly liable to ulcerate or slough.

The causes of œdema, which most concern the surgeon, are the pressure of cancerous, aneurismal, and other tumours on the great veins of a limb, and obstruction of the veins by phlebitis. A raised position, moderate support by bandages, and punctures made with a common sewing-needle, to let the serum exude, are the most rational palliative measures.

CHAPTER VIII.

HÆMORRHAGE.

Hæmorrhage, like serous effusion, may be a consequence, 1stly, of inflammation or excitement; 2ndly, of obstruction to the return of venous blood; and 3rdly, of structural weakness of the blood-vessels and impurity of the blood, as in scurvy and putrid fevers. The first form is called *active*, the last two *passive*.

(1.) *Active hæmorrhage* consists in an escape of arterial blood from the capillaries, when ruptured by distention caused by acute inflammation or violent excitement; and more or less of it doubtless occurs in every case of violent inflammation. It occurs during the formation of abscess in the areolar tissue and in the liver.

Hæmorrhage is known to accompany certain violent forms of pleurisy and pericarditis. But its most frequent seat is mucous membrane. Menstruation is the type of an inflammatory hæmorrhage of mucous membrane. Exfoliation of mucous membrane, which accompanies the hæmorrhage so notably in dysmenorrhœa, occurs also in dysentery, in cystitis, and in nephritis. The surgeon is chiefly concerned with epistaxis or hæmorrhage from the nose; hæmorrhois or hæmorrhage from the rectum, and hæmorrhage from the urethra during gonorrhœa. Sometimes the blood issues, not from the surface of the inflamed membrane, but from portions of exudation, which have become vascular, and whose newly-formed capillaries have been over-distended and ruptured. Granulating wounds bleed likewise.

Diagnosis.—Inflammatory or active hæmorrhage is distinguished from that which is the result of congestion or debility, by the presence of pain, heat, and throbbing, and of a febrile state of the pulse and system generally.

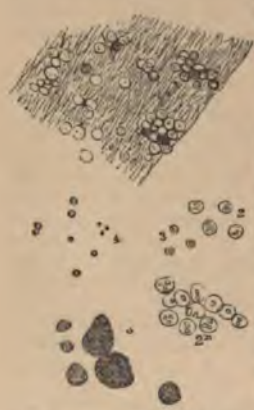
Treatment.—This form of hæmorrhage is to be treated by an antiphlogistic and cooling regimen. (F. 34, 35, 75). Cold, if it can be applied, perfect rest, and an elevated position, are the local measures.

(2.) In *passive hæmorrhage* the blood which escapes is venous. The principal instances of it are hæmorrhage from the nose in old subjects with diseased liver; melæna, or hæmorrhage from the liver, and passive menorrhagia. The chief remedies are, dilute sulphuric acid, sulphate of alumina, acetate of lead, catechu, gallic acid, and other vegetable astringents which increase the coagulability of the blood, and ergot of rye, which increases the contraction of the capillaries. F. 14, 186, 187, &c.

CHAPTER IX.

EXUDATION OF FIBRINE, AND ADHESION.

ONE of the commonest effects of inflammation is fibrinous e
the process by which organised adhesions or bands of false mer
are formed; cavities are filled up, membranes rendered thick,
and rigid, and the substance of organs infiltrated with solid dep
The *material* is, so far as we know, the same, whether
from the vessels or generated
tissues, as that which has b
scribed under the head of repai



It may very soon become pe
by blood-vessels, which no d
outgrowths from the nearest ca
(1.) It may be developed i
of the tissues capable of ren
i. e., fibrous tissue, bone, or epi
forming bands of adhesion, c
superficial deposits, and t
membranes.
(2.) It may undergo chan
beneficial sort, which cause i
rapidly absorbed; that is, if th
state of blood which caused th
tion be relieved, the latter r
dergo fatty degeneration, and
absorbed, or remain harmless
state commonly known as *yello
tubercular*.
(3.) From a continuance
irritation and afflux, the lymph may soften into pus. In som
as of phlegmonous erysipelas, diffuse inflammation, carbun
the like, the exudation is so *aplastic* and *cacoplastic* from
as to be incapable of organisation, and so poisonous as to be t
absorption, and it softens only into an amorphous puriform flu
Examples of adhesion.—1. After wounds, in which the e
nature at repair have been frustrated, a certain degree of inflam
ensues, and so soon as the inflammation abates, the reparat
terial takes the form of *granulations*. These are composed of
cells, in every variety of size, shape, and development, mix
filamentous intercellular matter. According to the older the
lymph effused develops itself into the cells: according to the
the cells on the surface increase and multiply, and form the

* 1, Lymph, with fibrils and corpuscles; 2, Pus; 2a, Pus acted on
acid; 3, Blood; 4, Oil globules; 5, Granular masses; 6, c. plastic a
cells filled with oily and granular matter.

lations. The deeper layers are, as to structure, converted into filamentous tissue, and as to chemical nature into gelatine, whilst the more superficial are still spherical and albuminous; and whilst the very surface degenerates into the creamy liquid called pus. This is the mode in which open wounds (or wounds which the skin will not cover) generally heal in the human subject; but it is an imperfect mode; because granulations are extremely liable to be diseased, because they entail a great waste of material which escapes in the form of pus, and because the scar is always larger than in the case of a wound healing by the primary reparative process. When two surfaces covered with granulations are made to unite, the union is said to be by *secondary adhesion* or by the *second intention*.

2. A second example is furnished by the acute inflammation of serous membranes; as pleurisy, which gives rise to the adhesions which so commonly bind the lungs to the inside of the ribs. Under rheumatic inflammation, the heart may be glued to the pericardium; in syphilitic iritis the anterior chamber of the eye may be filled with lymph. After injuries, the adhesions produced by inflammation of the pleura and peritonæum are of service in preventing the spread of exudation or of extravasated matter.

Mucous membranes, as we said at p. 36, are not commonly considered liable to adhesive inflammation, because the lymph effused is generally cast off, and does not become adherent or organised. Yet fibrinous flakes are common on inflamed mucous membranes; and if two abraded and inflamed mucous surfaces are placed in apposition and left undisturbed, they may adhere;—as sometimes happens in the vaginæ of female children;—in the os uteri and Fallopian tubes of prostitutes, and in the ureters and biliary ducts when abraded by the passage of calculi; and Mr. Hancock has shown the existence of organised lymph in the canal of the urethra, in cases of stricture.

3. When a natural reparative process has failed, the surgeon often excites adhesive inflammation, as the basis for another effort at repair. (See False Joint.)

4. Separation of fibrine may take place within the heart or vessels.

Granulations, if healthy, and proceeding towards a cure, are small, pointed, and florid; they bleed if wiped, and are not very tender. But they are subject to many disorders; being sometimes pale, bloated, and œdematous; sometimes degenerating into a pseudo-mucous membrane; sometimes breaking up suddenly, and being dissolved into a sanious fluid. When, however, the case proceeds favourably, the undermost are developed into fibro-cellular tissue, those on the surface form themselves into cuticle, and so the wound is healed.

Cicatrization.—This process of healing, or cicatrization, is attended with an absorption of inflammatory effusion in the vicinity of the wound, and a contraction of its margin, so that the wound becomes much smaller before any new cuticle is formed. Its edge then begins to look smooth and bluish, and a thin pellicle of new cuticle gradually spreads from the edge in a converging circle till the wound is closed.

The material that closes up the gap is called a cicatrix: it is a ba fibrous tissue covered with cuticle. It has no thickness, for granula do not really *fill up* gaps, as is sometimes said, and seldom form a more than one-third of an inch thick; and in the case of an exte gap the cicatrix is closely glued to the bone or fascia beneath, afterwards shrinks, becoming paler and likewise looser, through atr of the deeper portions.

The most favourable granulative cicatrization is attended with l if any, waste of material in the shape of pus.

ADHESIONS AND CICATRICES are extremely liable to shrink, and come atrophied. Thus, the extensive cicatrices left after severe b always contract greatly; and adhesions between serous surfaces n in the course of time, disappear entirely. After the liver or kidney been infiltrated with fibrinous effusion the whole organ is liabl waste. During certain states of constitutional cachexy (as the scur old fractures have become disunited, and old cicatrices have broken afresh into wounds; showing that the new tissue has less vitality t that of original formation.*

Treatment.—If it be wished to remove adhesions, or thickening, results of previous acute or existing chronic inflammation, the gen rules must be attended to which were laid down for the treatmen chronic inflammation. *Mercury* has a reputation for removing indu tion: but, as we have before said, it should be used as an eliminati and not to accumulate and cause ptyalism, F. 87. The local me that may be used to remove the thickening left by a quite subd inflammation of any external part, are friction, stimulating liniment F. 143, 150; gentle exercise; shampooing; pressure by bandages otherwise; cold affusion; electricity and galvanism; discutient lotio especially those of zinc, F. 117, or muriate of ammonia, F. 11 blisters, or other counter-irritants—always taking care not to prod active inflammation by too violent stimulation.

CHAPTER X.

SUPPURATION AND ABSCESS.

SECTION 1.—SUPPURATION AND ANALOGOUS PROCESSES.

SUPPURATION.—According to the doctrines stated in the prece ing chapter, when an inflammation continues to be excessive acute, or when there are certain defects in the composition

* In examining the body of a madman who had stabbed himself in the abd men fifteen different times during his life, the parts near the *most recent* wound were found united by considerable false membranes;—at the situation of so that were older, there were only a few thin cellular adhesions; whilst at th oldest, there was no trace of adhesion or false membrane whatever. Andra Anat. Path, vol. i. p. 486.

the blood, the fibrinous exudation becomes a creamy liquid called pus.

1st. *In Abscesses.*—When suppuration takes place in any cavity, or in the substance of the areolar tissue, or of any organ, an *abscess* is said to be formed. If the inflammation is of the variety called healthy or chronic, or circumscribed, the centre only of the exudation will soften; the circumference will form a cyst, containing the liquid, and not allowing it to spread. If the inflammation is low, or unhealthy, as in erysipelas, the whole of the fibrine will probably soften into a *puriform fluid*, to be presently described, and the abscess will be *diffused*.

2nd. *In open granulating wounds.*—In the case of wounds and other injuries, in which a portion of the tissues is left uncovered by skin, or of wounds, which have not united by adhesion, the exposed surfaces, after bleeding has ceased, and a thin reddish serum has ceased to exude, become glazed over with a grayish or buffy coat composed of fibrine and the white corpuscles of the blood. Two or three days pass, more or less; and the vicinity of the wound displays evidence of slight inflammation. The shiny surface comes off; under it is seen a granulating and suppurating surface.

3rd. *On mucous membranes.*—There can be but little doubt that the healthier a mucous membrane, the less mucus does it yield; only enough to keep the surface moist and clean. Under irritation or debility, an increase of secretion ensues. Under acute inflammation, blood, or at least serum mixed with lymph, may be effused, part of the epithelial layer may be shed, and the epithelial cells multiply hastily, the pus which soon forms being composed of serum, and small ill-formed epithelial cells.

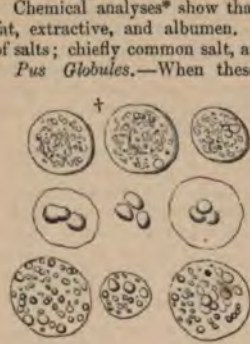
Physiological relations of Suppuration.—1st. Suppuration is essentially a morbid process; yet as it may accompany other processes which tend to a beneficial end (such as granulation), so it is customary to speak of it when accompanying such beneficial processes, as *healthy*, and to describe the product as *healthy pus*. Moreover, though suppuration be a morbid process, it often takes the place of other processes infinitely more morbid. Thus, after a very severe lacerated wound, when the patient has passed through several days of fearful constitutional excitement; or after sloughing or rapid phagedænic ulceration, nothing delights the surgeon more than the sight of healthy pus, because he knows that it announces at least an attempt at reparation, and the cessation of violent febrile excitement. 2ndly. The formation of abscess often seems to serve as a means for eliminating some noxious matter from the blood. 3rdly. Suppuration affords a mechanical means of removing foreign substances impacted in the soft parts. *Lastly*, if too profuse, it may exhaust the vital powers; decaying pus may be absorbed and bring on hectic fever.

Healthy Pus.—Pus is a yellowish-white, opaque fluid, of the consistence of cream: free from smell, neither acid nor alkaline, said to have a sweetish, mawkish taste, insoluble in water, although freely miscible with it, and very slow to putrefy. It consists of a thin serum,

holding a vast number of globules in suspension. Its usual specific gravity is 1·021—1·040; heat coagulates the albuminous elements of its serum; potass and ammonia convert it into a gelatinous mass.

Chemical analyses* show that pus contains water (86·1 per cent.), fat, extractive, and albumen. It also contains about 0·8 per cent. of salts; chiefly common salt, and muriate of ammonia.

Pus Globules.—When these are examined under the microscope they are found to be opaque spherical globules, apparently granulated like mulberries, but in reality smooth, as may be known by examining their circumference. They measure from 1-5000th to 1-2000th of an inch in diameter; some even are larger. They may be shown to consist of cell membrane, containing nuclei, oil globules, and minute granules. If water be added, they imbibe some of it, and become larger, more transparent, and less granular. If acetic acid be added, it brings clearly into view two, three, or four nuclei; and renders the other parts transparent, or so invisible, that they seem to have dissolved. Besides the globules, other smaller molecules are also found in pus in great abundance.



†

Mucous Pus or Muco-purulent matter.—Mucus consists of a viscid matter coagulable by acetic acid and containing epithelium. Under inflammation, it may be mixed with serum, blood, fibrinous flakes, epithelial casts, nuclei, and abortive cells and pus.

‡

PURIFORM FLUID is a fluid formed by the softening down of a fibrinous exudation, without the development of real pus globules. It constitutes the liquid yielded by carbuncles and unhealthy abscesses, by spreading ulcers, and by the fibrinous exudations which occur in the lungs and elsewhere, when putrid fluids have found their way into the blood. It exhibits oil globules, shreds and fragments of tissue, granules, and possibly abor-

* Vide Mayo, Med. Gaz., 19th Oct. 1839; Vogel, über Eiter und Eiterung, p. 35; Davy, op. cit. vol. ii., p. 468; Bonnet, Med. Gaz. vol. xxi.; Gueterbock, de Pure et Granulatione, Berol., 1837.

† The uppermost group gives a pretty accurate idea of the appearance of pus globules magnified 400 diameters. The middle figures represent globules treated with acetic acid; the lowest represent the appearances when pus is partially decomposed or treated with liq. potassæ. These figures were drawn from nature by Dr. Westmacott, under the superintendence of Dr. Johnson of King's College.

‡ This cut represents puriform fluid from a softened lymphatic gland.

tive cell formations; smaller than pus globules, less regular, and not giving the characteristic reaction with acetic acid.

SOFTENING is degeneration and liquefaction of the affected tissue, and of any fibrinous exudation with which it may have been infiltrated, although without the presence of true pus. It is a condition met with in the brain, either from disease of the arteries, or from a low degree of inflammation. Amongst the products of decayed exudations are the bodies known as *compound granular cells*. They were formerly called *exudation corpuscles*, because they were found in inflammatory exudations; but they are by no means peculiar to these; on the contrary, they seem to be formed by a process of fatty degeneration of almost every primary cell, and thus may be found in any cell-growth, healthy or morbid. For instance, they may be found in the colostrum or milk first secreted after parturition; in the decidua; and in enchondromatous, fibroplastic, cancerous, and almost every other morbid growth. They are unaltered by water and acetic acid; potass dissolves the cell-wall, and sets free the granules.† In some cases these bodies consist merely of an aggregation of fatty molecules.

SECTION II.—ACUTE ABSCESS.

SYMPTOMS.—Acute abscess (which, when occurring in the subcutaneous cellular tissue is called *phlegmon*,) commences with the ordinary signs of acute inflammation—namely, inflammatory fever; severe throbbing pain; bright redness; and much swelling;—firm in the centre, and œdematous around. The occurrence of *suppuration is indicated* by an abatement of the fever, and a change in the pain,—which is less acute, and converted into a sense of weight and tension. Then the tumour becomes softer, and loses its bright arterial colour; and as the quantity of pus increases, its centre begins to *point*, that is, to project in a pyramidal form, and *fluctuation* can be felt by alternate pressure with the fingers. After this, the parts between the abscess and the surface become successively softened and disintegrated. The tumour becomes more and more prominent; the centre exhibits a dusky-red or bluish tint, the cutis ulcerates, the cuticle bursts, and the pus escapes.

Deep Suppuration.—But where pus is formed under fasciæ, or deep in the mamma, or pelvis, and cannot quickly make its way to the surface, the pain is not relieved but often much aggravated by the increase

* 1, shows a cell from a fibro-plastic tumour; 2, from cancer; 3, from an ovarian cyst, and from the decidua,—all loaded with oil-globules: traced by the author from actual specimens, by the camera.

† Hughes Bennett on Cancer, &c., p. 153.

lymphatic vessels.

TREATMENT.—In a case of idiopat
abscess, the indication always is to re
of constitution on which it depends,
process of suppuration by warm pou
local injury, all exciting causes, such
be removed.

Poultices relax the skin, promote pe
the formation of pus, and expedite its
should be large, soft, and light, and m
or linseed meal, or of camomile flowe
bran sewed up in a flannel bag, which
as often as it becomes cold (F. 152), &

The *warm-water dressing*—that is,
linen dipped in warm water and cov
evaporation, and the *spongio-piline*—ar
in many cases, especially for irritable s
pain, they are not so soothing as the l
made poultice.

Respecting the *opening of abscesses*, it
rule, that if they point and become p
circumference, they *may* be left to burst
enlarge in breadth and circumference,
they should be opened. In the followi
geon's aid is imperatively demanded:

1. When matter forms beneath fasci
textures, such as the sheaths of tend
dense, and ulcerate with difficulty, the
surface, will burrow amongst muscles
abscess to great distances;—producing
disturbance, by its tension of the fasciæ
the parts beneath,—causing risk of exte
the future motions of the part. Hence
beneath fasciæ, or among tendons, or

irritant fluids; or when it contains an unhealthy matter, which might diffuse itself and spread the disease: as in carbuncle.

3. When an abscess is formed in loose cellular tissue (as around the anus), which would readily admit of great distension and enlargement of the sac, and more especially if the cellular tissue is partially covered with muscles (as in the axilla), under which the matter might burrow.

4. In suppuration near a joint; or in the parietes of the chest or abdomen; or under the deep fascia of the neck; lest the abscess burst into the serous cavities, or the trachea; or cause compression of, or burst into, the trachea, œsophagus, or jugular veins.

5. In suppuration of very sensitive organs, as the testis.

6. When it is desirable to avoid the scar which always will ensue when an abscess ulcerates spontaneously.

And in the first three of these cases it is much better to make an opening before matter has formed, than to delay it for one moment afterwards.

Abscesses may be punctured with a large lancet, used as in venesection, or with the sickle-shaped bistoury, commonly called *Syme's*; or, if deep and extensive, by a straight-pointed, double-edged bistoury. Holding it like a pen, the surgeon should gently plunge it in at a right angle to the surface, till it has entered the cavity, which may be known by a diminution to the feeling of resistance, or by gently turning the instrument on its long axis, so that a drop of pus may well up by its side. Then the aperture may be enlarged sufficiently as the instrument is being withdrawn. The puncture should be made at the lowest part, so that the abscess may empty itself, or else where the matter points most decidedly and the skin is the thinnest; and a very fine strip of oiled lint (called a *tent*) may be gently introduced between the edges of the opening, and be allowed to remain for the first forty-eight hours to prevent them from closing again. The matter should not be rudely squeezed out; but when the surgeon has given vent enough, he should let it gently flow out into a poultice or fomentation.

The poultice may be continued till all the pain has subsided, and not longer. And then the best plan is to apply a compress of linen or cotton-wool, and strips of plaster or a bandage, to bring the sides of the cavity together, and keep them so. If the cavity does not contract speedily, it must be treated as a *fistula*. If the suppuration continues profuse, tonics, change of air, and a good diet are advisable, in order to prevent hectic, and enable the constitution to repair the local mischief.

Mr. Hilton's Method for Deep Abscesses.—Supposing deep suppuration in the axilla, there is this dilemma: if the surgeon "plunge in a bistoury," he runs great risk of wounding a large blood-vessel; if he wait till the abscess come to the surface, the patient may die of irritation. In this case, says Mr. Hilton, "I cut with a lancet through the skin and cellular tissue and fascia of the axilla, about half or three-quarters of an inch behind the axillary edge of the great pectoral muscle.

At this point, we can meet with no large blood-vessel. . . . Then I push a grooved probe, or grooved director upwards into the swelling in the axilla; and if you watch the groove, a little opaque serum or pus will show itself. Take a blunt (not a sharp) instrument, such as a pair of dressing-forceps, and run the closed blades along the groove in the probe or director into the swelling. Now opening the handles, you at the same time open the blades situated within the abscess, and so tear open the abscess. Lastly, by keeping open the blades of the forceps during the withdrawal of the instrument, you leave a lacerated track or canal communicating with the collection of pus, which will not readily unite, and will permit the easy exit of matter." Mr. Hilton gives instances of the same method successfully employed in a deep abscess of the orbit, after fractured base of skull;—in deep cervical abscess; post-pharyngeal abscess with disease of cervical vertebræ; in abscess under the iliacus internus descending behind the femoral vessels into the thigh; and in deep abscess under the glutei. He has done it over and over again in abscesses formed upon or under the periosteum in the thigh. He often sees, he says, after dividing the fascia lata, the healthy muscles stand up boldly and clearly in the wound; and, instead of cutting through them, he runs his director right through them into the collection of matter, and then dilates the wound with the dressing-forceps. He advises the same course also in abscess on the interosseous membrane of the forearm.*

Absorption of Pus.—It occasionally happens that acute abscesses are cured by the absorption of their pus. This is likely to happen when, after acute inflammation, the matter remains without tending to come to the surface, and without pain: the means best adapted to promote it are moderate pressure, purgatives, and tonics.

By these means, in fortunate instances, the liquor puris may be absorbed, the pus corpuscles undergo degeneration and disintegration, and after remaining for some time as a fatty or cheesy mass, may pass again, in a molecular form, into the blood-vessels.

SECTION III.—HECTIC OR SUPPURATIVE FEVER.

DEFINITION.—Hectic (a Greek word signifying *habitual*) fever is a remittent fever, marked by daily paroxysms. It depends on a disordered state of the blood, whether from obstinate malassimilation, or from severe local disease with suppuration.

SYMPTOMS.—The patient generally displays great loss of flesh and strength, the skin is muddy, and the eyes hollow. Usually every afternoon or evening he has a fit of shivering, more or less severe, followed by heat and thirst, which render the early part of the night restless; then sleep and profuse sour perspiration come on. The tongue is red, and there is a marked tendency to diarrhœa. The pulse above 80 and soft.

* On the Influence of Mechanical and Physiological Rest in the Treatment of Accidents and Diseases. By John Hilton, F.R.S., &c., p. 121. Lond. 1863.

If the hectic arise from a local disease, it may cease instantly, on the removal of the disease, by operation or otherwise. But if the causes continue, and the malady increase, the diarrhœa and perspirations become more and more profuse and exhausting, the throat becomes aphthous, and the patient sinks.

CAUSES.—Hectic fever, more or less well marked, attends several of the great assimilative disorders of the blood, as diabetes. But that which interests the surgeon is its connection with suppuration; and there is no doubt that true severe hectic depends on the absorption of decomposing pus into the blood, and that the perspirations and diarrhœa are the means by which nature eliminates the poison.

In the case of certain deep abscesses (the writer, from his midwifery practice, has seen it in the breasts more often than elsewhere) there may be a daily attack of cold shivers, succeeded by heat and profuse fœtid perspiration, and attended by great debility, red tongue, and diarrhœa; and these symptoms, after lasting for days, may be relieved at once by opening the abscess.

It is often said that shivering is a sign of suppuration. This is not true absolutely, for pus may be formed without shivering. But shivering is a sign that matter, if formed, is beginning to be absorbed in a condition that renders it poisonous; and the occurrence of it, especially if attended with the other signs of hectic, renders it the surgeon's duty to look for local mischief.

TREATMENT.—The first indication is to remove the local disease if it can be done. The second is to support the strength. The third to treat symptoms.

The first may often be fulfilled by letting out pus, or cutting out a diseased part, or such other operation as may suit the individual case.

The second, by abundance of food, especially animal food, and good beer or port wine. Preparations of isinglass, or other fish or animal jelly, seem also to supply waste; and there are some cases in which feverishness is so great that the patient can take only milk and farinaceous food, as arrowroot, bread, &c.

The best tonics are bark and steel, especially the decoction of bark with nitric acid, F. 1; and the *Mixture* of Moses Griffith, F. 19.

Diarrhœa is best combated by pure meat diet and sulphuric acid, F. 24, 25; with small doses of opium. Sometimes the old-fashioned soothing medicines, chalk and bismuth mixtures, &c., are useful, and sometimes gallic acid. Perspirations are relieved, also, by sulphuric acid, and oxide of zinc.

SECTION IV.—CHRONIC ABSCESS; AND TYPHOID SYMPTOMS FROM PUTREFACTION OF PUS.

GENERAL DESCRIPTION.—Chronic abscesses may be the result of an evolution produced by a low and unsuspected degree of inflammation, or of some non-inflammatory scrofulous deposit. They most frequently are the result of diseased bone. They are mostly lined with a thin,

reddish-gray, distinctly-organised cyst;—there is little or no vascularity in the parts adjoining;—and the pus usually is thin and flaky.

SYMPTOMS.—When first detected, a chronic abscess appears as an obscure tumour, with a fluctuation more or less distinct according to its distance from the surface. It is free from pain, tenderness, swelling, and redness, unless far advanced, or accidentally inflamed.

PROGRESS.—These abscesses may attain an enormous magnitude, before the coverings ulcerate. When, however, from the increasing distension, or from some accidental irritation, this does happen, the skin reddens, inflames, and ulcerates, and so the matter is discharged.

TERMINATIONS.—(1.) In slight cases the interior of the sac granulates;—the reddened skin around the orifice ulcerates;—and the sore so formed may heal. (2.) If the restorative powers are weak, or the abscess is caused by a piece of diseased bone or some other source of irritation which is not removed, one or more *sinuses* may remain. (3.) If, on the other hand, the abscess is very large, or if, after the admission of air, the pus have not a free exit, a most serious train of consequences will ensue. The pus, exposed to the atmosphere, putrefies,—the hydrosulphate of ammonia (the product of putrefaction) is absorbed into the blood,*—and a train of typhoid symptoms comes on precisely like those which were produced by the air of a cesspool in Dr. T. H. Barker's experiments. There is hot and dry skin; dry and glazed tongue; parched lips; the formation of healthy pus ceases; the pulse is rapid and jerking; there is low muttering delirium, and picking of the bedclothes and jerking of the muscles of the arms and legs (*subsultus tendinum*); the bowels are paralysed and tympanitic, or else probably there is offensive diarrhœa, and the patient, if unrelieved, sinks comatose.

PROGNOSIS.—Hence, the danger of these abscesses will be great, if the sac has attained a large size, and has advanced so far towards ulceration that a spontaneous and permanent aperture is inevitable, more especially if it is connected with a carious bone which cannot be got at, and which will keep up the secretion of pus.

TREATMENT.—There are three *indications:* (1.) To amend the general health, and cure diseased bone, &c., or whatever may be the root of the evil.

(2.) Absorption of the matter may sometimes be effected by stimulants, in cases not arising from diseased bone, applied to the tumour; as the Emp. Ammoniaci cum Hydrarg.; or F. 160.

(3.) But if the tumour becomes large, it should be opened;—especially if there be much redness and thinning of the skin. And a different proceeding is requisite in different cases.

If the abscess is superficial and small, a sufficient opening should

* It may be detected in the blood and urine. The blood in these cases is black, and refuses to coagulate; which is precisely the effect produced by adding the hydrosulphate of ammonia to healthy blood. Vide M. Bonnet's Papers in the Med. Gaz. vol. xxi.; Dr. T. H. Barker on Sewer Exhalations; and Richardson on the Blood, Appendix I., 1858.

be made to let out the raspberry-cream-looking matter and the flakes floating in it; and some strips of adhesive plaster should be passed round the part, so as to keep the sides of the sac in apposition with a moderate degree of pressure. Thus a free and depending aperture being provided for the pus, the opposing surfaces of the cavity will often granulate and adhere; then the external aperture heals, and the case is cured. If this adhesion does not take place, stimulating injections may be used, such as F. 117 diluted;—or the cavity may be slit up, and made to heal from the bottom.

Large Chronic Abscesses.—If the abscess is very large, or if it is connected with disease of the spine (as in the case of psoas abscess), the surgeon must take care not to let air into the sac; nor to empty the sac suddenly, and leave its sides unsupported; else when the fluid pressure within is removed, blood will very probably ooze from the delicate vessels, and putrefy. A *small puncture* should be made at the most depending part of the tumour. Mr. Vincent recommends a trocar. As much matter as flows spontaneously should be permitted to escape, the parietes of the abscess should be brought together by careful bandaging, and then the puncture should be carefully closed by *collodion* or plaster, and the patient be kept at rest till it is healed. During the flow of the matter, the greatest care ought to be taken to prevent the admission of air into the sac. At the expiration of ten days or a fortnight, when it is nearly refilled, a second puncture should be made (but not too near the former), and should be healed again in like manner. This operation should be repeated at proper intervals, taking care never to let the abscess become so distended as it was before the previous puncture,—and using *moderate* support by bandages in the intervals. Thus, in fortunate cases, these repeated partial evacuations, combined with proper constitutional measures, may cause the abscess gradually to contract;—so that it either becomes completely obliterated or degenerates into an insignificant fistula.*

Perhaps a still safer method is to pass a long narrow knife through the skin, at a little distance from the abscess; then under the skin into the sac, so that the pus may pass through a subcutaneous canal, that shall be thoroughly valvular and exclude the air.†

M. Chassaignac's Drainage.—Large chronic abscesses in which there may be risk from sudden emptying of the sac, are just the cases for which the *drainage tubes* of M. Chassaignac are adapted. These are india-rubber tubes, about ⅛th inch in diameter, and perforated with numerous holes. Let us suppose a large chronic abscess. M. Chassaignac takes a long trocar, introduces it at the top of the abscess, and brings it out as near the bottom as may be. Through the canula a drainage tube is inserted; the canula is withdrawn, leaving the tube, whose ends are tied together for security. Pus oozes out constantly drop by drop, through the tube; thus the abscess is gradually emp-

* William Fergusson's Practical Surgery, 3rd ed. p. 92; and Lancet, Nov. 6, 1841.

† W. Adams, Subcutaneous Surgery, p. 48. Lond. 1857.

tied, and kept empty. Two or more tubes may be introdu
need be.

But if air have once gained admission into the cavity of the a
and the pus have become putrid, and prostration of strength an
brown tongue show its influence on the system, then the indic
plainly are, to make free openings and counter-openings, so as to
vent all lodgment of the putrid pus; and to wash out the sac
sionally with injections of warm water, containing a very little
solution of iodine. At the same time the strength must be suppo
and the evil influence on the blood neutralised by wine, soup,
and the nitro-muriatic or sulphuric acid, F. 1, 22, 25.

CHAPTER XI.

ERYSIPELAS, DIFFUSE INFLAMMATION OF THE CELLULA TISSUE, AND PYÆMIA.

SECTION I.—PATHOLOGY OF ERYSIPELATOUS INFLAMMATION

ERYSIPELAS is an unhealthy inflammation, which, wherever s
ated, exhibits the following characters:—It has a disposition to spr
widely along the surface of skin or membranes, or in the area
tissue. The lymph which is formed has no disposition to form a
within which the pus shall be confined; on the contrary, it is lia
to universal softening, and the exudations are diffused widely, and t
extend the disease into sound parts. Erysipelatous inflammation
liable to attack different parts, sometimes simultaneously, sometimes
metastasis; that is, leaving one part and flying to another, thus giv
evidence of its origin in a vitiated state of the blood. The differ
varieties of erysipelatous disease prevail epidemically together. Th
Dr. Ferguson tells us, that erysipelas and puerperal fever were genera
coexistent in his lying-in hospital, the mothers perishing of one and
infants of the other. These diseases are capable of direct propagat
by *infection*, *i. e.*, through the medium of gaseous emanations, and
contagion. Instances are now common enough, showing that the c
tagion of erysipelas may cause puerperal fever, just as inoculation w
the fluids of a female who has died of puerperal fever is a most f
source of diffuse cellular inflammation to the dissector.*

Since hospitals are frequently rather a curse than a blessing throu
the mortality arising from erysipelatous diseases contracted wit
their walls, or carried into the lying-in chamber, no pains should

* See Robert Ferguson on Puerperal Fever, p. 29; Storrs, of Doncaster,
first clearly proved the common origin of these and other septic diseases, in
Prov. Med. Jour., 23rd April, 1842; Nunnely on Erysipelas, Lond. 1841;
G. Gregory on *Ochlesis*, Lancet for July 15, 1848; Routh on the Puerp
Fever of Vienna, Med. Chir. Trans. vol. xxxii.

spared to obviate the causes, and to prevent the extension of these diseases. Hospitals should have rooms in which the convalescents should be during the day. The floors should be dry-rubbed and polished, not washed. The walls and ceilings should be whitewashed at regular short intervals. Ventilation should be constantly watched; a space of at least 1500 cubic feet be allowed for each patient in a ward. The feather beds and mattresses should be baked, and the bedsteads be taken to pieces and exposed to the air at least once a year. No patient should be put into a bed just quitted by another. The patients should be obliged, when practicable, to use the warm bath and soap, and when not able to do so their feet should be washed often. On the outbreak of the disease, all the inmates who can be moved should be sent away, and the infected ward be shut up. It ought to be a capital offence, to bring a patient labouring under erysipelas, pyæmia, sloughing sore, profuse and fetid suppuration, or the like, into any ward of a civil hospital amongst other patients. Such persons should be treated in out-buildings, or separate wards by themselves. Surgeons and pupils should not come to the bedside, especially *to a midwifery case*, immediately from the dead-house or dissecting-room, still less from a case of erysipelatous disease. The dressings and bandages used in any case should be destroyed, and tow, which may be destroyed when once used, should be substituted for sponge, which would be used again and again. Bags filled with charcoal should be placed so as to absorb all putrid vapours. Disinfectants should be used to all discharges, fæces, &c., and to all sinks, closets, and drains. Condy's, Burnett's, Macdougal's, or chloride of lime may be used, but cheap tincture of iodine is the best of any: this last may be put into plates under the beds to purify the air, F. 203.

SECTION II.—THE CUTANEOUS AND CELLULO-CUTANEOUS ERYSIPELAS.

DEFINITION.—Diffused inflammation of the skin, or skin and cellular tissue, with a tendency to spread.

SYMPTOMS.—The *cutaneous* or *simple* erysipelas is known by redness of the skin, which *disappears momentarily on pressure*;—considerable puffy swelling from serous effusion into the cellular tissue;—and severe stinging, burning, or smarting pain. The redness is generally of a vivid scarlet hue; but it will be faint and yellowish if the disease is attended with much debility, or if it affect the eyelids, scrotum, or other loose cellular parts, where it always produces a good deal of serous effusion. The nearest lymphatic glands are always swelled and tender.

In the *cellulo-cutaneous* or *phlegmonous* erysipelas the redness is deeper, and sometimes dusky or purple, and it is *scarcely*, if at all, *dispelled by pressure*;—the swelling is much greater, and is hard, brawny, and tense;—and the pain is not only burning, but throbbing.

Constitutional symptoms.—Both varieties are ushered in with shiver-

ing, headache, pain in the back, nausea, and bilious vomiting; and both are attended with fever, which will vary in its type according to circumstances. It may be of a sthenic inflammatory character, if the disease affect a young robust countryman: but it soon assumes a low typhoid character if the patient is old and weak; or if the disease were contracted in some close, foul, ill-ventilated hospital, or if a large portion of cellular tissue has begun to slough.

TERMINATIONS.—The *cutaneous* erysipelas may terminate, 1, in resolution, leaving nothing but desquamation of the cuticle with slight œdema; 2, but more frequently it produces large *bullæ* or vesicles from effusion of serum under the cuticle;—and these dry into scales, which peel off, and leave the cutis either healed, or superficially ulcerated. 3. Sometimes, however, it is followed by small abscesses. The ordinary duration is from seven to fourteen days.

Before its termination, however, this variety of erysipelas sometimes assumes a lingering erratic character, wandering progressively along the skin, and spreading in one direction as it fades in another. Sometimes it disappears entirely from one part, and flies by *metastasis* to a distant one; and sometimes it quits the skin suddenly, and some internal organ is affected with an inflammation having the same constitutional characters.

The *phlegmonous* or *cellulo-cutaneous* erysipelas *may* terminate as favourably as the simple variety;—but it more generally leads to unhealthy suppuration and sloughing of the cellular tissue;—in which case the swelling becomes flaccid and *quaggy*;—patches of the skin become purple, and covered with livid vesications, and these patches slough, giving exit to a thin sanious pus, and to flakes of disorganised cellular tissue. And not only the subcutaneous, but the intermuscular tissue and fasciæ may slough, rendering the limb useless, even if the patient escape with his life. Moreover, after a very severe attack of erysipelas, the cellular tissue is apt to be left in a hardened, brawny state, through infiltration with lymph.

PROGNOSIS.—This must be guarded if the patient is old, enfeebled, and habitually intemperate;—if the fever is of a low cast; if the malady is situated on the head or throat, and there is coma or great dyspnœa;—or if the erysipelas is of the phlegmonous variety, and a large portion of the cellular tissue and skin is on the point of sloughing. The return of suppuration in ulcers, and the formation of abscesses, are most favourable signs.

Local Varieties.—Erysipelas usually attacks any part of the body which is injured or wounded; and in new-born children the vicinity of the navel; but where there is no external injury it usually manifests itself on the forehead: whence it may spread to the scalp, throat, and trunk. Erysipelas of the scalp is apt to be complicated with headache and delirium in the early, and coma in the later stages; and erysipelas of the throat with great dyspnœa.

TREATMENT.—The indications for the *constitutional* treatment are, to purify the blood and to support the strength;—and for the *local*

ent, to allay irritation—to arrest the extension of the disease—
give free exit to sloughs and discharge.

etics and Purgatives.—On the first occurrence of the symptoms
etic should be given (F. 98), and be followed by five grains of
l, and by purgative draughts, every six or eight hours, as long
y bring away hardened lumps, or dark offensive liquid motions.
, 34.)

Sthenic Measures.—*Bleeding* is said to be required if the
t is young and vigorous, the pulse full and strong, the face
d, and delirium violent; and if the inflamed part is full, tense,
vidly red, and especially if seated on the head or throat; but in
cases, a small dose of mercury at night, F. 63; with very gentle
nts and carbonate or citrate of ammonia, F. 58, will suffice, after
l preliminary purging by calomel. The practice of bleeding in
ic disease belongs to a past generation.

t.—During the whole course of the disease, the patient should
a good quantity of nourishment; seldom low diet for more than
r two days; but beef-tea, soda-water and milk; barley-water
lemon-juice, and, in the later stages, good claret or port, even
y *ad libitum*, in proportion to the failure of pulse.

nics.—*Bark* should be given in *all* cases as soon as the tongue
es clean and the skin moist; but it should be resorted to without
if the pulse is soft, tremulous, or very rapid, the heat moderate,
he delirium low and muttering, or if suppuration or sloughing
commenced, F. 1.

ium may be given in full doses at bed-time in the later stages, to
restlessness, provided there is no cerebral congestion nor coma.
there is great irritation of the stomach, with sickness or diarrhœa,
repeated doses of hydr. c. cretâ et pulv. ipec. c. should be given
effervescing draughts, F. 64, 58.

CAL MEASURES.—*Leeches* are useful when the pulse is good, and
idness vivid, and the part throbbing violently, and especially when
hroat is inflamed. *Minute punctures* about one-fifth of an inch
made with the point of a lancet, often permit the discharge of
derable quantities of blood and serum; they are rather painful.
lotions may be used under similar circumstances. But *warm* or
poppy fomentations will generally be found more soothing, and
tically are safer than cold.—*Flour*, dusted on the inflamed part,
ft carded cotton wool, is often very soothing in simple erysipelas.
ssure by bandages is serviceable in the latter stages of most
;—and from the very first, if the inflammation be atonic and
natous.—*Stimulants*. Painting the surface with solution of *nitrate*
er, or *blisters*, or lotion of chloride of iron, are of great use in
ing a healthy exudation, and so putting a stop to tedious erratic
of simple erysipelas. In similar cases, the *extension of the*
e may sometimes be arrested by applying the nitrate of silver so
mpletely to encircle the inflamed part. When there is a tendency
aking, with diminution or disappearance of the external inflamma-

tion, warm cloths, moistened with turpentine or sp. camp. may be applied externally, and brandy internally.

Incisions are, to use a French expression, the *heroic* remedy in phlegmonous erysipelas. When the swelling is great, and increases rapidly; —when it is hard, tense, and resisting, not soft and œdematous, as in simple erysipelas; —when the pain is severe and throbbing; —when there is the least sensation of fluctuation or *quagginess:* or when the skin is becoming livid or dusky, or covered with livid vesicles, they are imperatively demanded. They are absolutely necessary for the discharge of pus and sloughs; —for, as James observes, these matters are neither brought to the surface by pointing, nor walled in by adhesion. And they are not merely apertures for the discharge of matter, but a very effectual means of cutting short the inflammation, by relieving the tension, and by emptying the distended blood-vessels. They are also requisite in erysipelas of the throat, when great swelling threatens suffocation by pressure on the trachea. They should be made of sufficient length—in as many places as required; —they should be carried quite deeply through the diseased tissues, and should be repeated as often as necessary. One, two, or three inches will be a sufficient length in most cases; but it can never be necessary to gash a limb from hip to ankle. They should not be permitted to bleed long; —and hæmorrhage, if profuse, is best stopped by continued pressure with the fingers on the bleeding points. The subsequent measures are poultices, followed by nitric acid lotion; and bandages to prevent lodgment of matter and sinuses.*

During any epidemic of erysipelas, the people within its range are liable to a kind of bilious fever; —*i.e.*, to all the constitutional symptoms without the local.

SECTION III.—PYÆMIA, AND THE CONSEQUENCES OF SEPTIC LIQUIDS INTRODUCED INTO THE VEINS.

Definition.—Pyæmia is a diseased state of the blood, caused by the introduction of decomposing animal matter; often producing numerous abscesses, or rapid effusions of puriform fluid into several organs.

Symptoms.—The symptoms are those of puerperal fever, erysipelas, and dissection wounds. If a patient, after parturition, injury, or operation, is seized with severe shiverings, pulse rapid, countenance anxious, weight about the heart, spirits low, healthy suppuration (if any) arrested, tongue dry, tight headache, sleeplessness, sallow skin, and nausea, this disease may be predicated. But there is an almost infinite variety in the further progress and specific symptoms in various cases, depending on varieties in the kind or mode of action of the blood-poison; and these we proceed to enumerate.

1. In some cases the patient sinks; life is extinguished by t

* Vide James, op. cit.; Copland, Dict.; Higginbottom on Nitrate of Silve., Copland Hutchinson's Surgical Observations.

of state of the blood, without the development of any local

a second set the poison expends its chief force on the liver, ...des an immense quantity of dark bile, discharged by vomit- ...purging.

...e bowels may be the part to which the poison is determined; ...re is great discharge of mucous, or serous, or bilious, or bloody ...of various colours and fœtor, and after death the mucous mem- ...found intensely congested. This too seems salutary in its in-

This second and third set of cases correspond to the bilious ...nteric forms of puerperal fever.

...flammation of the serous membranes may ensue; rapid pleurisy, ...ulness on percussion from effusion of bloody or turbid serum; ...enitis; or effusion into the head, with delirium and coma; or ...is, tenderness and tightness of the abdomen, patient lying on ... and not breathing with the diaphragm.

... skin may be, though less commonly, affected. There may ... offensive perspirations, or in some cases an attack of ..., or an eruption of carbuncles, or of pustules like those of ...x.

...ally, the most characteristic symptom is that from which the ...ame is derived; namely, the production of profuse suppura- ...We cannot affirm that pyæmia is caused by absorption of pus,* ...; neither could it be proved if it were so, because it, like ery- ...is attended with enormous production of the white corpuscles of ...d, which are virtually indistinguishable from pus. Yet we know ...s which form in the veins may break up and be disseminated; ...t pyæmia most readily follows injuries or diseases of the bones ...llow fetid discharges to pass into the veins. There can be no ...bt a portion of the blood, spoiled by this admixture, is de- ...s the form of unhealthy fibrine, which usually softens down ...*form fluid*. Thus are formed the abscesses, which are some- ...alled *secondary*, or *metastatic*, or *purulent depôts*,—names ...re correct enough, in so far as they imply that the puriform ...deposited in, and not elaborated by, the suffering part. What ...t shall be is determined by anatomical conditions. The lungs ...m unhealthy blood brought from any part of the system; ...how pneumonia following operations is explained. The liver ...r if the seat of contamination be the abdominal system of veins. ... of lung or liver may undergo gangrene through embolic ...on of the artery or vena portæ. Abscesses may form in ...or the joints, or the areolar tissue; and it is curious to notice ...y often occur symmetrically; in both elbows, or ankles, ...nce. They may form with extreme rapidity. The patient, ...y be lying in bed, with anxious, sallow countenance and rapid ...t no particular local symptoms, may all of a sudden complain ...isting pain in the shoulder or calf, or *some other* part. This ...his well stated in *Virchow, Cellular Pathology, by Chance, passim.*

may pass off by degrees, with no great or mischievous effusion; or, on the other hand, in a few hours the part so complained of may be found a bag of pus.

Diffuse Inflammation of the Cellular Tissue.—This is an important member of the pyæmic group. It appears to be the cellulo-cutaneous erysipelas, without the affection of the skin. A rapidly-increasing swelling appears on one of the limbs, or on some part of the trunk. Its surface is tense, shining, and usually pale. When pressed upon, it feels in some cases hard and resisting, but more frequently it yields that peculiar, semi-elastic sensation described by the term *boggy*, or *quaggy*. There is always most excruciating pain,—which in some cases is burning and throbbing, in others heavy and tensive. The disease is invariably attended with fever of an asthenic character. The pulse is always frequent; it may be sharp and jerking, but is without strength and steadiness. The countenance is anxious and haggard; the mind irritable and desponding, and delirious at intervals; respiration quick and laborious. In unfavourable cases, low muttering deliriuim, copious offensive perspiration, and jaundiced skin, usher in the fatal termination.*

This form of inflammation is produced by dissection wounds, glanders, and snake-bites.

Prognosis.—This disease is always serious; often fatal. The patient's chances of recovery may be measured by strength of pulse, clearness of intellect, sleep, or the reverse. Repeated shiverings are of the worst omen. The disease may prove fatal rapidly; or the patient may linger, and slowly sink from abscesses or visceral disease; or, he may recover, if the amount of local mischief is not great, and if the excretory organs are enabled to get rid of the poisonous material before the patient is quite exhausted. The author has been repeatedly struck with the immense quantities of black bile and of lithate excreted by women recovering from slight attacks of puerperal fever.

Causes.—1st. The predisposing causes are those that produce a low state of constitution, and render the blood incapable of forming a firm clot; such as profuse loss of blood; deprivation of food; anxiety of mind; organic disease; impure states of the atmosphere; residence in the contaminated air of an hospital. The fact so well brought out by Mr. Charles Hawkins, that single women are ten times more prone to puerperal fever than married ones, shows the effect of misery and starvation in rendering them prone to pyæmia. 2ndly. Disturbance of the coagulum in a wounded vein; as by exercise of an arm after venesection, or imprudent movements soon after parturition; local circumstances interfering with the closure of veins, such as the patulous condition of the veins of bone, of the liver, and of the sinuses in the

* See two papers in the Edinburgh Medical and Surgical Journal for 1825, vol. xxv.; Copland's Dict. *Art.* Cellular Tissue; James on Inflammation; Travers on Constitutional Irritation; and Butler on Irritative Fever, Devonport, 1825, which gives an account of an extraordinary visitation of this disease in Plymouth Dockyard in 1824.

...-mater, which allows of the ready passage of diseased fluids into ... A very large proportion of cases of pyæmia are found to follow ... and operations of the bones. 3rdly. Infection or contagion ... puerperal fever or erysipelas; or inoculation with putrid fluids.* ... It sometimes follows exanthemata or fevers; and sometimes ... to be induced by cold.

Treatment.—The leading indications are, 1. to purify the blood; ... keep up the strength. For the first purpose it is well to give one ... grain dose of calomel, and to follow it by purgatives; saline pur... F. 33, 34, 35, 42, if the bowels are torpid—milder ones, as ... and castor-oil, if they are inclined to diarrhœa; endeavouring ... away black or yellow fetid stools, not mere water or slime. ... may sometimes be of service. For the second purpose, good ... and port wine are of most value; but it will be very desirable ... the patient's taste. Some patients crave for bottled beer; ... for soda water, with or without brandy; or milk, or lemonade, ...-muriatic acid, F. 22, or simple effervescing draughts; and in ... all cases the dictates of appetite may be safely yielded to. ... of potass has a repute; whether deserved or not is another ... Pain and restlessness may be allayed by regular doses of ..., administered in sufficient quantity to produce sleep at night ... tranquillise the nerves; such as eight or ten grains of Dover's ... at bedtime, with a small dose of hyd. c. cretâ; and smaller ... of Dover's powder during the day. In other respects, the prac... must treat symptoms: local pain and tenderness by a few ... and fomentations; inflammation of pleura, or peritonæum, or ... by leeches and bran or mustard-poultices, or blisters; diarrhœa, ...ding, must be moderated by chalk or bismuth mixture, and ...gine; and in all respects the strength should be husbanded, and ...stitution assisted in its struggles with this too-fatal disease. ...'s emphatic declaration at the London Meeting of the British ... Association should not be forgotten, that the few patients whom ... knows to recover owed their lives to being kept in a current of ...

...never suppuration or puriform deposit takes place, incisions ...ssary, on the same principle as in phlegmonous erysipelas.

SECTION IV.—PHLEGMASIA ALBA DOLENS.

...s disease apparently depends on the reception of poisonous fluids ...o veins, the coagulation of the blood in them, and the exudation ...ous matter into the tissues in which the affected veins and their ... are situated.

Symptoms are peculiar, and well expressed by the threefold ... There is swelling, considerable, firm, and not œdematous; with

* Robert Ferguson on Puerperal Fever, Lond. 1839; Arnott, Med. Chir. ... vol. xv.; Henry Lee, Med. Gaz. vol. xxxviii.; *London Journal of ..., March and July, 1850; also Med. Chir. Trans. for 1852.*

the surface of the skin pale; intense heat; very excruciating pain; and loss of all power of using the muscles. The importance of this disease depends very much upon the circumstance whether it is purely local, or accompanied by general blood-infection. If local, the consequences are obliteration of venous trunks, obstinate swelling and œdema of the parts below; perhaps abscesses around the affected veins. If accompanied with pyæmia, there will be some one or more of the consequences of that disease which we have just described. This, like all other diseases of its class, is most common in women after parturition, especially if they have *lost much blood;* and the open veins of the uterus, and the fetid discharges with which they are in contact, furnish a ready explanation of the cause. The part affected is generally the thigh. But it is not confined to women, as the following cases from the author's note-book will show. A very stout gentleman had for two years a small fistulous orifice in the ham, resulting from a boil. This became the seat of fresh inflammation, and was freely laid open with great relief. On the fifth day he was rather feverish; there was an obscure doughy swelling, not œdematous nor fluctuating, over the inner part of the thigh; there was no pain, but a sense of tightness. This increased during the next three days, and became painful, till the whole thigh was greatly swelled and doughy, the leg œdematous. A hospital-surgeon insisted that there must be deep-seated suppuration; and made a long and deep gash on the outside of the thigh. The parts cut seemed gelatinous, and exuded very little blood, no pus, and no serum. The pulse gradually rose; headache, diarrhœa, and delirium came on. The thigh continuing in *statu quo*, the hospital-surgeon made deep punctures in the upper part of the limb with a grooved needle: neither serum nor pus exuded. Death on the twentieth day. The writer has also seen it in a gentleman recovering from a sloughing sore produced by scarlet fever.

Treatment.—For the local symptoms, nothing answers so well in the case of women, as warm poppy fomentations, or bran poultices sprinkled with laudanum; and, later in the case, gently smearing with opiate liniments, F. 147, and wrapping up in flannel bandages. The bowels should be gently relieved. Opium should be given to allay the pain. All lowering and violent remedies are hurtful.*

CHAPTER XII.

ULCERATION.

SECTION I.—THE PATHOLOGY OF ULCERATION.

DEFINITION.—Ulceration consists in the progressive softening and disintegration of successive layers of the ulcerating tissue.

PATHOLOGY.—One of the most vexed questions in pathology is, what is an ulcer? And this is seen in the disputations about the so-called ulcer-

* See Mackenzie on Phlegmasia Dolens.

of the cervix uteri. Some say that a given disease is ulcer, others that it is not. We shall endeavour to be precise, by separating *excoriation* or *epithelial sore*, or *chafing* of skin or mucous membrane, from *ulcer*.

(1.) By *excoriation*, we mean a loss of epithelium, or change in the character of epithelium. Thus, if the skin in the chinks and creases of a fat child's thighs be kept moist and dirty, the dry cuticle is replaced by a secretion of purulent stuff. If the cuticle be stripped off the skin by violence, or if it be raised by scalding water or any other *vesicant*, the same happens. A mucous surface may have enlarged papillæ and copious secretion of epithelium and pus, and look like an ulcer, but no loss of substance. Hence, in many so-called ulcers of skin and mucous membrane there is no chasm or loss of substance, rather the reverse. Enlarged papillæ and profuse secretion of epithelium of all grades between healthy epithelium and pus, constitute the patches known as intertrigo, raised ulcer, and mucous tubercle. There are many conditions of the skin, such as psoriasis, in which there is increased vascularity and copious growth of epithelium, which do not resemble ulcers, because the epithelium is dry; but if similar patches appear on the fauces, or any other moist surface, they look like raised ulcers.

(2.) True ulcers generally begin as excoriations. Then the skin beneath begins to melt away, its surface being covered with a tenacious slimy matter. If this is wiped off, or separates, the surface underneath is seen to be red, and it easily bleeds. Supposing the case to proceed, there is formed a chasm, eaten into irregular hollows with intervening red eminences, which easily bleed if touched; its edges are ragged or undermined; the surrounding skin red, hot, and swollen; there is a thin serous or bloody discharge, and a severe gnawing pain. An ulcer having these characters is called *inflamed*, or *irritable*, and may always be considered as extending itself.

PATHOLOGY.—The ulcerative process consists, as was shown by Goodsir, of two apparently incompatible processes—one formative, one destructive. It usually happens that a part whose vitality is already impaired, such as the skin of the leg of a dirty old woman whose veins are varicose, becomes inflamed. It becomes somewhat infiltrated with lymph or cell growth; this softens and perishes, and the infiltrated skin with it bit by bit. In some ulcers very little of the formative element is seen, healthy or morbid. Such ulcers are *indolent*. Such are the ulcers of the mucous membrane of the stomach, of the cornea, &c., which have sharp edges, looking as if punched out, but with no swelling, redness, or other sign of *action*. Others evidently depend for their spread on the increase of a morbid cell-growth with which they began; such as the syphilitic, scrofulous, epithelioma, cancerous, typhoid and tubercular ulcers of the intestines, &c. The morbid cell-growth in the form of granulations often attains such dimensions as to be called *fungous*; and as it resembles fungi in cellular structure, so it does also in the rapidity with which it may perish and rot, or slough.

PREDISPOSING CAUSES.—The *Tissues* most disposed to ulce are the skin, and the mucous and synovial membranes. The a tissue ulcerates very easily, but muscles, blood-vessels, and n very slowly; so that they often appear to be as it were dissected spreading sores, by the destruction of the areolar tissue around Tendons and ligaments are also very slow to ulcerate owing to physical qualities; but cartilage, bone, and the cornea are in c constitutions extremely liable to it. The serous membranes rarely ulcerate primarily.*

The *Constitutions* most liable to ulceration are those whic weak. Anæmic maid-servants have ulcers of the stomach; scro children have ulcers of the skin, cornea, and synovial memb and feeble old persons give way in the legs.

The *parts* most disposed to it are those whose circulation is weak and languid; such as the legs: and more especially if the be varicose. Tall persons are said to be more frequently affected ulcers of the legs than the short.

Defect of nervous influence predisposes parts to ulcerate or m Ulcers of the cornea have followed injury to the fifth, and ulcera the hand has followed injuries of the median nerve.† (See p. 34

EXCITING CAUSES.—In constitutions or parts predisposed to slightest irritation may be sufficient to excite ulceration. In the h it may be produced by the continuous application of some ir such as continued pressure, or contact with poisonous secretions.

Ulcers present many varieties, which may be classed under heads. 1. *Healing.*—They may be in a state tending to repar as the healthy ulcer. 2. *Stationary.*—Their surface may ha imperfect form of organisation, under which they may be incapa healing, though they are not necessarily spreading; the weak a dolent ulcers are examples. 3. *Spreading.*—They may be und influence of the destructive process which formed them originall which is still causing them to spread; as the phagedænic.

SECTION II.—THE VARIETIES OF ULCERS.

I. THE HEALTHY or HEALING ULCER is nothing more t healthy granulating and cicatrizing surface. The granulatio small, numerous, florid, and pointed, and yield a moderate secret healthy pus. The edges are smooth and covered with a wh bluish semi-transparent pellicle, which is gradually lost on the n of the granulations. In favourable cases such an ulcer may c granulate and suppurate, and may fill up with moist lymph, rapidly cicatrizes.

Treatment.—The only treatment required will be a little dr

* There is a specimen of ulceration of peritonæal coat of stomach. Or Digestion, 76, Musée Dupuytren, Paris.

† See cases quoted by Paget. Med. Gaz. N.S. vol. iv. p. 1023. Paget tures by Turner, 2nd ed. p. 32. Hilton, Lectures on Rest, p. 192. Séquard. Lectures on Central Nervous System. Philadelphia, 1860.

re be much discharge, or the water-dressing, or simple ointment, re be not. If there be not much discharge, the dressings should changed more frequently than every second or third day. If ulations are too luxuriant, they may be touched with lunar , or washed with some astringent lotion (F. 117), and dressed with . If the granulating surface is very extensive, or if all applica- agree with it, as sometimes happens, it will be expedient to form on its surface; by sprinkling a little chalk on the surface, or by a stick of lunar caustic over the surface of the sore, as recom- by Mr. Higginbottom. This salt instantly coagulates the the sore, and forms a white pellicle, which soon becomes dry , and is much less irritating than an ordinary scab. If the favourably, suppuration ceases, and cicatrization will be found which it is detached.

HE INFLAMED ULCER, with which we may conjoin the IRRI- ULCER, are hot, tender, and subject to gnawing pain. The red and easily bleeds; the discharge is thin and ichorous. The ation is the leg; the class affected, the labouring population; ing cause, an unhealthy state of skin from degeneration of ; the exciting cause, any injury whatever occurring at a time health is deranged. A thin, foul, copious discharge is gene- the natural process of elimination, and requires purgatives.

ment.—The patient should be kept in bed with the limb raised . The first point is to amend the general health. For this if the tongue is white, and the patient feverish, active purga- be given (F. 33), with salines (F. 39). For the local treat- the first place soothing applications should be resorted to; and , from very extensive experience, most strongly recommends py lotion (F. 121) applied warm, by means of pieces of lint with oiled silk, and changed three times daily. Washing be effected without touching the sore. Plain bread-and-water (F. 153) and lead lotion sometimes answer well. If warm ous aggravate the pain, cold evaporating, or saturnine lotions , &c.) should be used, the sore being protected by a piece of or simple dressing.

feverishness has been relieved, and the bowels well opened, be relieved by henbane, or hemlock, or F. 30; or, if very and there is great mental anxiety, the patient should have such of solid opium at night as will insure sleep, and such smaller ring the day as may be requisite.

if the soothing plan ceases to do good, *very mild stimulants* may in the form of lotions, applied by means of small pieces of lint ghly soaked, laid gently on the sore, and not beyond the edges, ered with oiled silk, or lint thickly spread with spermaceti nt. The lotions of nitrate or acetate of lead, or of zinc (F. 116), ck wash, are the best. Should these not answer, and the pain ulcer depend evidently on irritable *surface*, and not on inflam- the surface may be destroyed *by lunar caustic*, or *by* nitric acid.

III. THE WEAK ULCER has large, pale, flabby, and insensible granulations rising above the margin of the skin, and showing no disposition to cicatrize.

IV. THE INDOLENT ULCER has its surface smooth and glassy, and of a pale, ashy colour, like a mucous membrane. Sometimes, however, it displays a crop of weak fungous granulations. The edges are raised, thick, white, and insensible; the discharge scanty and thin. Such ulcers are often stationary for a great length of time; but from any slight cause of irritation, may enlarge rapidly by ulceration or sloughing; and even when they have made considerable progress in healing, the granulations and cicatrices that have been months in forming may perish in a few hours from some constitutional disturbance or local injury.

Treatment.—The general rules are, to promote constitutional vigour by good diet and tonics, to excite the local action by various stimulants, and to support the venous circulation in the affected part.

The following is perhaps the best plan of curing these ulcers. A number of pieces of lint, throroughly soaked in the nitric acid lotion, should be laid on the sore, and be covered with a warm soft poultice. These applications should be changed twice a day, and be continued till the discharge becomes healthy, and granulations begin to arise. During this time the patient should be confined to bed and be purged. Afterwards, when the surface is clean, the following mode of dressing may be adopted. First, some pieces of lint, saturated with the nitric acid lotion, or zinc lotion, or with some other stimulating substance, should be laid on the sore. Then strips of adhesive plaster, about $1\frac{1}{2}$ inch wide, should be applied *two-thirds round the limb*, from an inch below the ulcer to an inch above it; and in applying each strip, the edges of the sore should be drawn together with a moderate degree of force. Next, a compress of soft linen should be placed over the plaster,

and, finally, the limb should be well and evenly bandaged from the toes to the knee; observing that the bandage is to be applied most tightly below, and more loosely by degrees as it ascends.

y with which the dressings should be changed must
ate of the discharge; for if that be profuse they should
y day; otherwise from twice to four times a week will

rely noticed by writers, but perhaps of more con-
ost plasters, is the observance of *perfect cleanliness.*
ered how filthy the habits of many persons are, who
legs and feet unwashed for weeks and months to-
be wondered that skin so neglected should, in the
shows a very imperfect vitality; and the author is
erience, that daily washing the lower limbs with a
and yellow soap and water, is one of the best means
decayed powers.
n of treatment, the patient may, after the first few
moderately; but he should not stand about, nor sit
ng down.
strapping irritate the skin, the empl. plumbi, spread
split leather, or the isinglass plaster, will answer

the plastering and bandaging are adapted for most
ate application to the ulcer will require to be fre-
Sometimes the strapping may be applied without
dry lint may be placed under it; or lint imbued
ulphate of copper, or alum; or with lotions made by
nce of the tincture of myrrh, or of benzoin (comp.),
to four ounces of water; or the balsams of copaiba
tallic preparations agree better in general than the
uthor fancies that resinous lotions and ointments are
n is irritable and *eczematous*, or covered with scales
readily peel off. In such cases plasters cannot be
. hyd. nitric. oxid. is very useful;—and the ung.
ulut. is praised for its efficacy in reducing thick cal-
green ointment is worth a trial. F. 171.
s of Treatment.—From the middle of the last cen-
rgeons of St. Thomas's Hospital were in treaty with
Half Moon Street for the purchase of an infallible
g ulcers, or rather from time immemorial to the pre-
le of plans recommended for the treatment of ulcers
ly that they all often fail.
the basis of many plans; as Baynton's and Scott's,
h the affected limb is enclosed in strips of plaster,
from the foot upwards.* A well-applied calico
of service. A laced stocking, or elastic stocking, is
sure may be combined with exclusion of the atmo-

scriptive Account of a New Method of Treating Old Ulcers
. 1797; Burnes, Lancet for 1847, vol. i.; Critchett, James
nd others in Lancet for 1848 and 1849; *Burgess's* Cazenave,
, 1853, vol. i. p. 566.

sphere; as in the plan of Mr. Stafford, who recommends old, deep, indolent ulcers to be treated by filling up their cavity with a mixture of one part of Venice turpentine, and four of bees'-wax, melted, and poured in warm. Mr. Syme covers an indolent ulcer with a blister. M. Malgaigne is said to use in some cases a warm iron held at a little distance from the ulcer, so as to dry its surface. *Heated air*, or *fumigation* with vapour of sulphuret of mercury, or of iodine with sulphur, has been used by Mr. G. A. Walker and others. The affected limb is put into a tin case, or large jar, provided with a heated iron at the bottom, and with a grating above this, to prevent the patient from being burnt. On the heated iron there is to be sprinkled, just before the patient's limb is subjected to the treatment, a powder composed of thirty grains of sulphur, six of cinnabar, and two of iodine; and the top of the apparatus should be covered with a thick cloth, to prevent the vapour from escaping. The limb may be thus fumigated for fifteen minutes every day, and the quantity of iodine gradually increased fourfold.

Mr. Gay has called attention to the fact that cicatrization proceeds only from the cutis vera, and, consequently, from the edges of an ulcer; that there appears to be great difficulty in cicatrizing a wide surface; and that nature causes the skin to contract, so as to cover the vacancy, in preference to forming a large cicatrix;—and that the healing of many ulcers is delayed because the surrounding skin cannot contract; either through adhesions which bind it down to the subjacent parts, or through extensive loss of skin, or from the fact that the sore is situated on a projecting part, as the ankle. Hence he proposes, in some cases, to liberate the edges of the sore by incisions parallel to, and at a little distance from them; or to excise the edges and surface of the ulcer, when firmly bound down by hardened tissue.

Should old ulcers be healed?—The propriety of healing old ulcers has often been made a question, inasmuch as certain diseases, and especially apoplexy, palsy, and mania have been said to come on afterwards. Sir E. Home specified the following cases in which a cure ought not to be attempted. 1. If the ulcer be "evidently affected with the gout, having regular attacks of pain, returning at stated periods; and those attacks similar to what the patient has experienced from gout in other parts." 2. If an ulcer habitually occur whenever the constitution is disordered. 3. If the patient be very infirm and old; for under these circumstances the removal of an habitual source of irritation, or the diversion of an habitual afflux of blood may prove fatal; more especially as very old ulcers have been known to heal spontaneously a short time before death.

To these cases must be added that of ulcers on the legs of stout women, about the critical time of life, and displaying a tendency to discharge copiously as the periodic uterine flux diminishes.

On this point we may observe, 1, that in the case of every habitual ulcer, purgatives should be freely used during the cure, and for some time after it. 2. That if, spite of this, there be symptoms of congestion in the head, an issue or a seton in a convenient situation may

answer the purpose of an ulcer in an inconvenient one; and, therefore, that with these safeguards ulcers on the legs may always be healed,—if possible.

VI. FISTULA, or SINUS, consists of a narrow channel lined by a pale pseudo-mucous membrane, which may or may not lead to a suppurating cavity. In old cases the parietes of the tube are often dense and semi-cartilaginous.

Causes.—Fistulæ are produced when abscesses are not thoroughly healed from the bottom; when there has been a defect in the bandaging or in providing proper outlets for the discharge; or when there is some standing cause of irritation, as a ligature, or a piece of dead bone, which keeps up a discharge of pus.

Treatment.—The first indication is to remove any source of irritation that may happen to exist, and diseased bone should always be looked for. The second, to prevent the lodgment of matter; for which purpose it may perhaps be necessary to make another opening. The third indication is to produce, by stimulating injections, especially the strong caustic lotion, the destruction of the pseudo-mucous lining, and to cause the exudation of plastic matter, so as to fill up the fistula. At the same time the sides of it should be kept constantly pressed together with compress and bandage. If these means fail, the fistula should be slit up with a bistoury; and then a thin piece of lint be introduced in order to prevent premature union of the cut edges, and make it heal from the bottom.

If there have been a succession of small unhealthy abscesses in a part, or if ulceration have spread irregularly in the cellular tissue, so as to leave the skin ragged and extensively undermined with tortuous sinuses, it may be advisable to destroy the whole of the parts so diseased by the potassa fusa; and this will stimulate the neighbouring sound parts, so that when the slough separates, a healthy surface will be left, which may be healed by the ordinary means.*

VII. THE VARICOSE ULCER occurs in consequence of a varicose state of the veins of the lower extremity. This greatly impedes the return of blood, and, by producing habitual venous congestion, weakens the parts, and renders them prone to ulceration. The ulcers are usually three or four in number, situated above the ankle. They are oval in shape, indolent in their progress, and neither extensive nor deep; but they are attended with considerable pain, which is of a deep-seated, aching character.

The *Treatment* must be directed principally to the veins; and for this we must refer to the chapter on that subject. We will merely observe here, that the applications to the ulcers must be suited to their condition, whether irritable or indolent; and that great relief to the pain is sometimes obtained by opening one of the enlarged vessels, and abstracting a moderate quantity of blood. The advantages of proper support by bandages or laced stockings, or by encasing the limb in strapping from the foot upwards, need scarcely to be noticed. Some-

* Liston, Elements of Surgery.

times there is a constant desquamation of the cuticle, with
charge, for which the best remedies are equal parts of
and milk, or the ointment of chalk, F. 164, or oxide
F. 131, or 188.

VIII. THE SLOUGHING ULCER is formed whenever ei
other varieties of ulcer is attacked with sloughing,—which
larly liable to occur to the *indolent*, when subjected to undu
Or, this name may be given to ulcers originally produced b
ing of the skin,—as on the legs of the dropsical.

Treatment.—The best applications are warm fomentatio
decoction, to which a little spirit has been added; poultic
or carrots; or the nitric acid or chloride of lime lotion
the creosote ointment, F. 163, which the author particul
mends.

IX. PHAGEDÆNA is a peculiar variety of ulceration in wh
exudation, and infiltration of the affected part, go hand in hand
decomposition. The surface of the sore is irregular, gener
or yellowish; the discharge serous or bloody, and often ext
fuse; and the pain extreme. Some cases are attended wit
acute inflammation, the margin of the sore being high
swelled, and red,—others with atony and debility, the m
pale, dusky, or livid.

Causes.—This disease may be induced either by extraor
irritation, or by some peculiar constitutional disorder. It
primary or secondary venereal sores, in consequence of filth
ance, the abuse of mercury, or of a weakened and vitiated,
habit, or of some peculiarity in the venereal virus. Sometim
in the throat after scarlatina; it may attack a blistered s
the constitution has greatly suffered from an acute and
disease, as measles, &c.; sometimes it affects the mouth o
children, constituting *cancrum oris*, *noma*, &c.

Treatment.—One of two courses may be taken. The *so*
sisting in the administration of opium with bark, wine
nourishment, and the local applications directed for *irri*
especially a weak solution of tannin, F. 131. This w
found successful; if not, recourse may be had to the
of the diseased surface by caustics, in the manner
p. 78.

X. SLOUGHING PHAGEDÆNA, or HOSPITAL GANGREN
most closely allied to diphtherite, or to the dry rot in timb
there are rapid propagation and decay of some parasitic
of the tissue which it infests. Its *causes* are, (1) *great loc*
combined with a vitiated state of the constitution. (2)
that is, the application of poisonous matter to a woun
infection; that is, the reception of poisonous miasmata in
We shall first treat of it as it occurs sporadically in civil pr
it bears the name of *sloughing phagedæna*: and next, of
serious visitations that decimate the patients in crowde

ary hospitals, whence it derives its other name, *hospital gan-*
.*

irty or forty years ago it was common in London hospitals,
ially in the case of young prostitutes, who had been exposed to
and wet, drink, starvation, venereal sores and discharges, and a
bed vagrant life;—especially, too, if salivation were superadded.
it is seen from time to time in the prostitutes who lie out in Hyde
. It is especially liable to be induced by the too free administra-
of mercury, or by intemperance and exposure to wet during a
urial course. The worst cases, however, appear to arise from
cted local irritation without any specific virus; as from acrid
arges and defective cleanliness. Mr. Lawrence mentions the case
young woman who had suffered from severe small-pox, and from
hora after it. The continual moisture from the rectum, with a
us discharge from the vagina, irritated and inflamed the skin of
nates, and caused a large sloughing phagedænic excavation on both

mptoms.—" It usually commences as a highly-irritable and pain-
boil, surrounded by a halo of dusky-red inflammation, and much
ted; the patient also in general having mucous discharges from
agina, and a diffused redness of integument in the vicinity of the
nda." There are severe darting and stinging pains, which are at
intermittent, but gradually establish themselves as a constant
ptom, with occasional exacerbations. When the pustule is
ured, the exposed surface of the ulcer displays a stratum of ad-
nt straw-coloured flocculi, mottled with darker points of reddish-
n and gray. The sore thus formed soon enlarges in breadth and
h; the edges become everted, and attended with a circumscribed
ening which is surrounded by dusky inflammation and diffused
swelling. The surface is composed of gray or ash-coloured
ghs, which may become brown, or resemble coagula of blood. The
arge is reddish-brown, and peculiarly fœtid, and there is occa-
lly severe hæmorrhage. Meanwhile the agonising pain, the
orrhage, and the absorption of putrid matters, soon induce severe
tive fever,—with loss of sleep, anxiety, restlessness, thirst, and
asting diarrhœa;—which, if not relieved, may produce death in
t three weeks; and, as delirium is rare, the patient retains a
rable consciousness of severe suffering to the end.†

OSPITAL GANGRENE is the name given to this affection when
ring in military and naval practice. It is engendered by crowding
ther a number of sick and wounded men, and by inattention to

n civil hospitals any serious attack of hospital gangrene is almost unheard
Yet it appeared in 1844 in University College Hospital. Liston, Lancet,
vol. i. p. 87. In the Middlesex Hospital in 1835, South's Chelius, vol. i.
The disease appeared in St. Bartholomew's Hospital and in St. George's
847; C. Hawkins, Med. Gaz. N.S., vol. iv. p. 1026. An account of its
ps in the British camp after the battle of Ferozepore, by Mr. Taylor, sur-
to the 29th Regt., is quoted by Guthrie, Lancet, 1848, vol. ii. p. 714.
Wellbank, Med. Chir. Trans vol. xi.; Lawrence, Med. Gaz. vol. v.

cleanliness and ventilation. It frequently is a concomitant of dysentery or typhus, originating in the same sources. It may affect any kind of wound, or even a mere bruise.

Symptoms.—According to Mr. Blackadder, it begins in the form of a livid vesicle at the edge of a wound or sore, accompanied with an occasional painful sensation like the sting of a gnat. Sometimes it first appears as a small livid spot on the sore, and near its circumference. In either case the disease soon spreads, and converts the whole surface of the ulcer into an ash-coloured or blackish slough. The discharge, if previously healthy, is at first diminished in quantity, and sanious; but soon becomes profuse, dirty yellowish, or brown, and offensive. According to Mr. Blackadder, the hospital gangrene is at first a purely *local* affection, like the sloughing phagedæna; and he says that the constitutional symptoms do not make their appearance before the third or fourth, sometimes not till the twentieth day.*

But the disease, as observed by Dr. Hennen, began with constitutional symptoms, headache, nausea, perhaps bilious vomiting, quick pulse, hot skin, and an inflamed, dry, glassy, and painful state of the wound; to which succeeded sloughing of the surface of the wound, great swelling of the edges, and the other local and constitutional symptoms of sloughing phagedæna.†

It thus appears that the hospital gangrene may be either a local disease, caused by the influence of poisonous matter on a wound, or that it may be constitutional from the first, and be caused by the absorption of a septic poison into the blood.

Treatment.—The indications in the treatment of all the forms of sloughing phagedæna are, 1, to destroy the diseased surface and its secretions; and 2, to correct the disorder of the system.

The first indication is to be carried into effect by means of caustics. The concentrated nitric acid may be used in the following mode, as directed by Mr. Welbank. In the first place the sore must be thoroughly cleansed, and *all its moisture be absorbed* by lint or tow. The surrounding parts must next be defended with a thick layer of ointment: then a thick pledget of lint, which may be conveniently fastened to the end of a stick, is to be imbued with the acid, and to be pressed steadily on every part of the diseased surface till the latter is converted into a dry, firm, and insensible mass. This application of course causes more or less pain for the moment; but, when that subsides, the patient expresses himself free from his previous severer sufferings. The part may then be covered with simple dressings and cloths wet with cold water. "It is always prudent, often necessary," says Mr. Welbank, "to remove the eschar at the end of sixteen or twenty hours, and then, if the patient be free from pain, and the ulcer healthy and florid, it is to be treated with common stimulating dressings.

* Observations on Phagedæna Gangrenosa, by H. Home Blackadder, Edinburgh, 1818; Guthrie, Commentaries on Military Surgery, 6th ed.

† Principles of Military Surgery, by John Hennen, M.D., F.R.S.E., 3rd ed., London, 1829, pp. 217, *et seq.*; Sir G. Ballingall's Military Surgery; Dr. Boggie on Hospital Gangrene, Edinburgh, 1848; Velpeau, Lancet, 1848, vol. ii. p. 172.

such as cerat. calaminæ, or solution of argenti nitras, or a cerate of turpentine, which may be melted and poured in warm." If, however, there be any recurrence of pain, or the least reappearance of the disease, the acid is again and again to be applied till a healthy action is restored.

Many other caustics and antiseptics have been used for the same purpose, as arsenic, creosote, iodine, &c. The French prefer the actual cautery. Some surgeons have been successful with much milder applications; as solution of opium, and even saturated solution of sugar. But the Americans, from their large experience in their unhappy war, prefer *bromine*, applied so as to saturate the diseased surface.*

As for the general treatment;—the patient should be narcotized by chloroform during the application of the caustic. Opium should be given in sufficient doses to procure sleep at night, and to relieve pain during the day. If the disease, as observed by Hennen, begin with shivering and fever, the treatment may be begun with purgatives, as directed for erysipelas, p. 63, to which this disease is most nearly allied. Bandages should be applied to a stump, so as to check the tendency to exudation. The same rules are applicable also as regards diet, since it is on wine or brandy, beef-tea, and other forms of nourishment, and yellow bark with nitric acid, that the surgeon's chief dependence is to be placed. Change to a pure dry air, free ventilation, and destruction of all putrescent matters, need not be more than mentioned.

XI. GANGRENOUS INFLAMMATION OF MUSCLE, as described by Dr. Lyons,† from his observations in the Crimea, generally affected soldiers who had received wounds, or suffered amputation in the thigh. With little or no swelling or pain, or change in the skin, the muscles gradually melted down into a soft, putrid, shreddy mass, and were discharged with immense quantities of fetid ichor. Indistinct febrile symptoms, with diarrhœa, accompanied the local disorder. The patients were generally exhausted by hæmorrhage and discharge in the course of from two to six weeks.

XII. MALIGNANT PUSTULE (Charbon) is a contagious and very fatal disease, common in France, but almost unknown in England. It commences as a little dark-red spot, with a stinging or pricking pain, on which there soon appears a pustule or vesicle seated on a hard inflamed base. When this is opened, it is found to contain a slough, black as charcoal; and the sloughing rapidly spreads, involving skin and cellular tissue, and sometimes the muscles beneath.

The account given of this malady by the continental writers is exceedingly confused; but it appears certain that it is caused by infection or contagion from horned cattle, which at certain seasons are affected with a precisely similar disease; and it further appears that, like hospital gangrene, it may commence in two ways:—By general infection

* Ample evidence of the superiority of bromine is given by Frank H. Hamilton, Am. Med. Times, Oct. 31, 1863, and by Drs. Moses and Thomson, Am. J. Med. Sc., April, 1864. It arrests the disease when nitric acid fails, and effects cures quickly. Dr. Hachenbach advises *turpentine*, Am. Med. Times, May 28, 1864.

† Report on the Pathology of the Army in the East, Lond. 1856.

of the system, from respiring air loaded with miasmata from diseased animals, or from eating their flesh; or by local inoculation of the diseased fluids. Mr. Lawrence gives an account of a man in Leadenhall Market, who accidentally smeared his face with some stinking hides from South America. The part touched by the putrid matter very soon became red, and swelled, and mortified, and the mortification spread over half the cheek. He has also met with two other cases affecting persons in a horse-hair manufactory. It is believed that flies which have alighted on the ulcers of the diseased animals convey the virus, and infect other animals and human beings.

The constitutional symptoms and morbid appearances are those of putrid typhus; the treatment, both constitutional and local, is the same that we have directed for hospital gangrene.*

XIII. THE ULCER OF THE CELLULAR MEMBRANE, which burrows under the skin and destroys that tissue, must be treated as the fistulous or weak, according to circumstances.

XIV. MENSTRUAL ULCER. This name is given to ulcers occurring in chlorotic young women, and exuding a sanguineous fluid at the time of their monthly discharge, if that be absent. Wounds made in operating will frequently do the same.

Treatment.—The chlorosis must be remedied by steel, aloes, &c., and the ulcer be treated on general principles.

XV. LUPUS NON EXEDENS (*Serpiginous Ulcer of the Face*) is a most obstinate form of ulcer affecting the face, chiefly of young women of a delicate or scrofulous constitution. It begins either as a shining, soft, circumscribed swelling of the skin, usually on one ala of the nose, which ulcerates; or else as a mere crack or small excoriation, covered with a thin scab, under which it slowly spreads. When the scab is removed, the discharge, which is scanty and viscid, soon dries and forms another larger one. The ulcer is constantly spreading in one direction, and healing in another; it may last for years, and wander over the whole face, completely destroying perhaps the alæ of the nose or the eyelids, but in other parts not penetrating the entire thickness of the true skin. The cicatrix is excessively irregular and shining, and of a dense whiteness, causing perhaps eversion of the eyelids and distortion of the features; in some parts it feels soft and pulpy. The cause and pathology of this affection are unknown. Ulcers of the same nature infest the lining membrane of the nose, the stomach, and intestines of scrofulous young women. The *treatment* consists in the use of soothing local applications, such as water-dressing, black wash, or very weak solution of nitrate of silver or of lead, and of a nutritious diet, cod-liver oil, sarsaparilla, bark, iodide of iron, and other tonics; in some cases of the *chloride of arsenic* in the dose of ten drops thrice daily at meal times, F. 97, from which the author has seen remarkable benefit in cases treated by Mr. Hunt. A mild purgative, F. 38, should

* Lawrence, Med. Gaz. vol. v. p. 392; Dict. de Méd. *Art.* Charbon, *Pustule maligne*; Schwabe, Brit. and For. Rev. vol. vii. p. 550; Lond. Med. Gaz., 21st Oct. 1842; South's Chelius, vol. i. p. 65.

...ast before the menstrual period. If the surface form a scab, ...ferable it best to use no application at all.

LUPUS EXEDENS (*Corroding ulcer* of Clarke, *ulcère Rongeante*, ...er of Paget; *Cancroïde* of Lebert; *Esthiomène* of Huguier; ...ne cancerous ulcer, and *Noli me tangere* of older writers*) ...characterised by slow but constant increase, rebellious to all ...rms of treatment, and ultimately leading to fatal consequences, ...ath. Examples of it are found in the corroding ulcer of the ...ad in the lupus, or so-called cancroid ulcer of the skin of the ... may affect pharynx, œsophagus, or rectum. The exact ...and cause of the disease are unknown. It is not cancerous; ...a infiltration of cancer cells nor yet of epithelium; the part ...ulcerates cleanly away, as if cut out with a punch, but up ...gs of the ulcer the tissues seem healthy, or at least contain ...ents as are found in the base of all ulcers; and there is ...ling nor hardness nor adhesion of the part, nor of the ad- ...lymphatics. The corroding ulcer of the uterus is most ...in women past child-bearing; lupus exedens of the face in ...dows forty, especially women.

...arts of the face most commonly affected are the nose and the ...der the eye. The disease may begin as a small vascular wart, ...mall shining tubercular swelling of the cutis vera, as a little ...like a mole covered with dried cuticle, or as a small *chap*, or ... In this condition it may last for an almost indefinite time, till ...h it spreads, forming a foul excavated irregular ulcer, with ...ungranulating surface, and scanty ichorous discharge, eating ...ways it in breadth and depth, till not merely the nose, or ...child may have perished, but the entire face is converted into ...of ulcer, with the eyeball dropping into the mouth.

Treatment.—Everything may be hoped from free and early caute- ...but recollecting the name *noli me tangere*, the surgeon must ...to *destroy* thoroughly, and not irritate by inefficient mea- ...of caustics, therefore, the most energetic should be chosen, ...and nitrate of mercury, P. 195; the Vienna paste (or ... of caustic potass with quicklime); the chloride of zinc, or

..., the arsenic is that which from long experience is believed ...most efficacious. The most convenient mode of applying it ...form of *Mayer's paste*; which is composed of 15 grains of ...ic, 75 of cinnabar, and 35 of burnt sponge, made into a thick ...a few drops of water. This should be thinly spread on the ...ce (previously cleansed from discharge and scabs) of the ulcer, ...er on a small portion of its surface if large, and be covered

...Lupus and the Chloride of Zinc, Med. Gaz. vols. xvii. and xviii.; and ...Surg. Art. Cauterants; Earle, Med. Chir. Trans. vol. xii.; Travers, ...Burgess's trans. of Canevave, p. 250; Brodie, Surgical Lectures; ...Cancer, p. 248; Liston, Lectures in Lancet, 1844, vol. i. p. 775; ...Prat. des Maladies Cancereuses, 1851, pp. 594 and 658; Paget's ...Surgical Pathology, vol. ii. p. 452.

with a piece of soft lint. The pain which follows is very severe, and the redness and swelling even alarming; moreover there may be vomiting and purging, symptoms which must be met by the administration of repeated doses of solid opium. At the expiration of a fortnight, if the whole surface were not cauterized at once, a second portion may be attacked in the same way. The eschars are some weeks in separating, and if the surface which remains is unhealthy, it must be destroyed again and again.

The chloride of zinc is generally mixed with three or four parts of flour (as used originally by Canquoin), or with two parts of freshly-burned plaster of Paris (as recommended by Mr. Ure, who introduced it to the notice of English surgeons). Then it is made into a paste with a few drops of water, spread over the ulcer, and allowed to remain for four or five hours. It is nearly as painful as the arsenic. The concentrated sulphuric acid is also a good caustic.

The general health must be improved by the remedies directed for the *lupus non exedens*, including the cautious and long-continued administration of arsenic, F. 97.

In cases in which cauterization cannot be performed effectually, the general and local palliative treatment are the same as of cancer.

CHAPTER XII.

MORTIFICATION.

SECTION I.—MORTIFICATION IN GENERAL.

DEFINITION.—Mortification signifies the death of any part of the body in consequence of disease or injury.

VARIETIES.—Some persons use the terms *mortification*, *gangrene*, and *sphacelus*, indiscriminately; but it is better to signify by *sphacelus* an utter and irrecoverable loss of life, and to restrict the term *gangrene* to the state which precedes, and commonly (but not inevitably) terminates in sphacelus; and in which perhaps the part may be supposed to be still capable of recovery.

Another distinction is made between *humid* and *dry* gangrene. The *humid* is a consequence of inflammation, or of obstacle to the return of the venous blood; and the mortified part, being loaded with fluid effusions, soon undergoes decomposition; whilst the *dry gangrene* is generally a consequence of deficient supply of blood, or of constitutional causes, and is either preceded by no inflammation at all, or by one so rapid that there is no time for interstitial effusions to occur, so that the mortified part becomes dry and hard. In the humid it is called a *slough*, in the dry gangrene an *eschar*. Many kinds of humid gangrene ought rather to be classed under the head of ulcer: as the hospital gangrene, which is the chief example of it, the sloughing ulcer, &c.

is into *constitutional* and *local*. By *constitutional*
it that which primarily originates in constitutional
mortification is understood that which has ori-
ury, and by which the system is not implicated,
es not sympathise in a violent or dangerous degree.*
symptoms of mortification in general are, that the
red, then livid or blue, or greenish; it loses its
nger feels the point of a needle; blisters form on the
bloody serum, which exudes as it does from a dead
grene proceed to *sphacelus*, the part may become
; if moist, it will decompose and stink; and will
and crepitate on pressure from gases evolved by
terstices.

ER FORMS.—We may begin with the *traumatic*,
e varieties of injury which either kill parts out-
n so that they cannot go through the processes of
for their repair; such as severe bruises, long-
s of a child's head upon the bladder in hard labour,
ionless body upon a hard bed;—wounds especially
mpound and complicated fractures, gunshot wounds,
d others which cause great infiltration of blood
rangulations, as in incarcerated hernia, or when a
wisted on its axis, or embraced by another portion,
r fracture apparatus is put on a limb too tightly,
e complete and summary, or imperfect, and cause
tion of venous blood. *Irritants, i.e.*, all substances
the health and quiet of tissues; such as extreme
oist; all sorts of irritant poisons, and caustics, &c.;
scent liquids, as those of charbon, and carbuncle,
f syphilitic poison. The injection of irritant
olar tissue, as when a zinc lotion, intended for a
d into the scrotum, or when urine escapes from

natic causes of mortification, few exceed interference
ery and vein of a limb, especially of the artery;
nd that has severed it, or an operation in conse-
f from punctured wound or rupture of an artery,
ltration of blood, gangrene is the more likely to
on of a chief vein is not so dangerous. Division
as some influence. *Disease of arteries*, atheroma,
nd *embolism*, that is, obstruction by clots, are like-
ly of senile gangrene.
tional causes, are debility, privation, exposure,
scurvy, and other blood diseases. Sir B. Brodie
feet mortified after he had been profusely bled. The

ures on Inflammation; Guthrie, G. J., F.R.S., A Treatise
, p. 116, 3rd ed. Lond. 1827; Case of Spontaneous Gan-
ded. Gaz. N.S. vol. v. p. 244.

feet are most liable to mortify under such circumstances, next the finger-tips, nose, and ears. Of course constitutional debility *predisposes* to mortification from local causes that otherwise would be insufficient; hence the gangrene of the feet of the poor soldiers after standing in wet and cold trenches before Sebastopol;—hence the frequency of sloughing of the skin over the hips and trochanters after long illnesses; and the danger lest blisters applied to children after measles and scarlatina should cause sloughing.

The *ergot of rye* has the reputation of causing gangrene of the extremities by some specific action in closing the arteries. Perhaps the starvation, sure to be associated with a diet of spoiled corn, has more to do with it.

Mortification is commonly said to be one of the terminations of inflammation. This is true to a certain extent;—if the part inflamed be peculiarly situated; thus, for example, the cornea may slough in acute conjunctivitis; the skin of the penis or even the glans in acute inflammation, with much swelling; the ends of the fingers in whitlow; or if the part inflamed be already diseased and weakened;—as, for example, the skin of the legs of an old woman. There are some special blood-poisons which produce local inflammations that almost always have something gangrenous;—as the small-pox pustule; scarlatinous sore-throat, boil, carbuncle, and phlegmonous erysipelas.

The tissues most disposed to mortification are the gelatinous; as areolar tissue, tendons, and ligaments, if the tissue surrounding them have been destroyed; bone, if deprived of its periosteum; next, the skin, especially if the subjacent tissue have mortified or have become infiltrated with fluid. Muscles, blood-vessels, and nerves resist it most.

Whilst gangrene is spreading, the dark colour is diffused, and insensibly lost in the surrounding skin; but when its progress is arrested, a healthy circulation is re-established up to the very margin of the sphacelated portion, and a bright-red line of adhesive inflammation (called the *line of demarcation*) separates the living parts from the dead. And the appearance of this line is most important as a means of *prognosis*, because it shows that the mischief has ceased, and that there is a disposition to repair its ravages.

Separation of the Mortified Part.—It is at this bright-red line of demarcation that the dead part is separated by ulceration. A narrow white line, consisting of a narrow circular vesicle, and formed by a separation of the cuticle, first appears on it; and when this is broken, a chain of minute ulcers is seen under it. These gradually unite and form a chink, which widens and deepens till it reaches the bone; meanwhile the dead bone is cut off by a process to be hereafter described: thus the slough is entirely detached, and then a granulating and suppurating surface remains. In this manner the whole of a mortified limb may be spontaneously amputated; the bone and tendons separating higher up, and being more slowly detached than the skin, muscles, and blood-vessels. When the adhesive inflammation has duly occurred, this process of separation is unattended with hæmor-

s, the vessels being obliterated by the effusion of lymph and coagu-
n of the blood within them. And this coagulation extends some
ance from the mortified part, so that a limb has been amputated in
thigh for mortification of the leg without the loss of any blood from
femoral artery. Sometimes, however, as in hospital gangrene,
processes of adhesion are deficient, and the blood is found fluid
e vessels, so that the separation of the slough is attended with
re hæmorrhage.

Constitutional Symptoms.—The constitutional symptoms of mortifi-
on (that is to say, making a distinction between mortification and
disease which may have gone before and led to it) are those of
ression. If it be very extensive—if the adjacent parts be unhealthy,
s no disposition to form the line of demarcation, but, on the con-
ry, with a greater tendency to serous effusion, or diffuse inflamma-
—or if the mortified part be of great importance, as intestine or
g, the constitutional symptoms will be of a low typhoid cast; there
be great anxiety, hiccough, a jaundiced skin, a soft, or rapid
eakly, and jerking pulse, and frequently profuse perspiration of a
averous odour. This indicates the fact that mortification introduces
ew element of danger:—to wit, the absorption of putrid liquids from
mortified part.

Diagnosis.—It is important not to mistake the lividity and vesica-
n of bruises, especially when they accompany fractures, for gan-

From a cast in the King's College Museum. This patient was a destitute
, and the gangrene arose from starvation.

grene. They may easily be distinguished by their sensibility temperature, and by the fact that in gangrene the whole cuticle lost its adhesion to the cutis, so that pressure will cause the ve shift its place.

GENERAL TREATMENT.—The indications are, 1st, To treat original disease or injury which may have caused the gangrene, or *he* causing it to spread; 2ndly, To promote, if possible, the forma of a line of healthy inflammation whereby the progress may be arre and to accelerate the ulcerative and suppurative process whereby sloughs are cast off; 3rdly, To protect the patient's system from a tamination by disinfectants; 4thly, To maintain the strength, and t the general health.

I. For the first indication we must refer to the Sections on the d ferent Injuries, Fractures, Syphilis, &c.

II. The second and third indications are fulfilled by applic which serve to mummify the dead parts, and to act as gentle stim lants on the living. Such are ointment of creosote, with a linse poultice over. There are other so-called terebinthinate applications Peruvian balsam, Friar's balsam, turpentine, &c., but creosote is best; lotions of the chloride of zinc or iron, F. 117, 127. P tices of carrot, beer grounds, and yeast have special virtues in sloughing sores. The air of the apartment should be kept pure, a need be should be impregnated with vapour of iodine, chlorine, vi or pastilles. In the present state of chemistry, it is a disgrace surgeon if he cannot keep a wound from stinking. Cotton thoroughly dusted with bismuth, or liniment of bismuth and glyc F. 149, or charcoal poultice, have the double effect of soothing, a absorbing ill odours.

III. The strength must be maintained by food and wine; res ness be allayed by opium; and much good will besides be obtained bark. For food the best beef-tea thickened, F. 196: with eggs, such other nourishment as the stomach will bear. Such wine, bra or spirit, or good beer must be given as the patient *likes*, and as h accustomed to.

Opium is of prodigious utility from its power of allaying ir bility; so that it renders the constitution insensible as it were to local mischief—or, in Hunter's language, "It does good by not let the disease do harm to the constitution." It may either be given small doses frequently repeated, or, if there be at any time very g restlessness, especially towards night, it will be better to give a dose at once; such as forty or fifty minims of the tincture, or grains of the solid opium. The most efficacious preparations of are the decoction of yellow bark, and Battley's liquor cinchonæ fl the value of which the author learned many years since from Farre. It may be given every six hours, combined with nitric Sir B. Brodie and Mr. Vincent believe that ammonia, if too long severed in, depresses the vital energies. Their practical experience confirmed the conclusions arrived at by those who have studied

naturally cease. Sir A. Cooper mentions a case in
ad leg was separating favourably by itself through the
projecting bones were sawn off, with a view of ex-
cess. A few granulations were accidentally wounded,
hæmorrhage that ensued was fatal.*
be proper to *amputate without waiting for the line of*
e mortification be local as to its cause; as, for instance,
of a limb from severe compound fracture or from injury
the large arterial trunks. This practice is sanctioned
hria, Brodie, S. Cooper, Lawrence, Velpeau, James, and
in. We may add, that amputation seems to be justi-
resource whenever there appears little or no disposition
ue, and whenever it spreads rapidly. "Where gan-
r. Guthrie, "is rapidly extending towards the trunk of
ut any hope of its cessation, the operation is to be tried;
ely succeeded, where death would in a few hours have

II.—ON SOME VARIETIES OF MORTIFICATION.

ATION FROM OBSTACLE TO THE RETURN OF VENOUS
form of mortification mostly affects the lower extremi-
who labour under dropsy from diseased heart, and it is
l by great œdema. It may occur primarily, or may be
f inflammation, which if it attacks œdematous parts is
terminate in gangrene. In the former case, the skin of
limb, having become pale, smooth, glossy, and tense,
ed aspect of a dull red or purple colour, from distension
eous veins. "Then at some part where the congestion
there the skin is less yielding, as over the tibia or above

occurs; and the slough, which is mostly an oval patch of skin and lular tissue, separates.

Treatment.—The part should be placed in an elevated positio numerous punctures should be made with a needle, to let the exude. The mortified part, and the ulcer that results, are to be tr by warm poultices of yeast, with stimulating dressings, of which nitric-acid lotion is the best.

II. MORTIFICATION FROM PRESSURE, BED SORES, &c.—When patient is confined to bed with some very tedious and debilitat malady, as a fever—and especially if he has not strength to shift posture occasionally—the skin covering various projecting bony p (as the sacrum, brim of the ilium, or great trochanter) is apt to inf and rapidly ulcerate or slough; and more particularly if irritat neglect of cleanliness or by the contact of urine. The first thing complained of by the patient is a sense of pricking, as though were crumbs of salt in the bed. The part, if examined at first red and rough; then becomes excoriated and ulcerates, or turn and mortifies. This accident is particularly liable to happen spinal cord has been injured. It is well to remark that the sometimes slough, apparently from stagnation, at the fold of t which hangs down, and not where the bones press on the bed.

Treatment.—When long confinement to bed is expected, it is plan to apply some stimulant to the skin of the back and hips, to it to secrete a thicker cuticle, and enable it to bear pressure Nothing can be better for this purpose than brandy or eau de Co If the part seems likely to suffer, it may be covered with a broad of calico spread with soap plaster; and small pillows, or mac cushions, or ox-bladders half filled with water, or water-cushion vulcanised india-rubber, should be arranged so as to take off the from the part affected; and the patient should be made to shift position often, or occasionally lie on his face. The soft poultice (F. will be found of great service. After sloughing has commenced, ung. resinæ or F. 163 is the best application.

III. SENILE GANGRENE.—A form of *dry gangrene* affecting fingers or toes. *Symptoms.*—In one instance which came under writer's observation, the patient, æt. 70, with diseased heart, c plained for some time of numbness and pricking at the tips of fingers. Next they looked bluish, and the cuticle peeled; then surface of the skin black. But far more frequently it commences purple or black spot on one of the smaller toes; from which spot cuticle," says Pott, "is always found to be detached, and the under it to be of a dark-red colour." "In some few instances, the little or no pain; but, in by far the majority, the patients feel uneasiness through the whole foot or joint of the ankle, particular the night, even before these parts show any mark of distemper, or b there is any other than a small discoloured spot at the end of o the little toes."* Its progress in some cases is slow, in others

* Pott's Chirurgical Works, 8vo. Lond. 1771.

f the arteries. Hence the foot is imperfectly nourished; d liable to pain and numbness if heated after being cold; n, or any other trivial source of inflammation, is sure to gangrene. A similar kind of gangrene sometimes attacks e leg.

ion mostly happens to old persons of the better class, espe- have been great eaters. They are generally found to have ir and teeth, and their face and hands betray a languid It mostly attacks men. Mr. James,* however, has seen an of forty-two, who had disease of the heart; and Brodie thirty-six.

t.—It seems agreed now, that this disease should not be stimulating plan. If there should be any vivid inflamma- ed pulse the patient should be kept in bed; the bowels pened; the diet be restricted to fish and broth; and der be given at bed-time, to allay pain. But should the ble the diet must be more generous. The foot may be lint, and covered with oiled silk. Brodie recommends a mine dressing to be laid on the part, and the whole limb wrapped in repeated folds of cotton wool, and afterwards a silk handkerchief. If there is much discharge this may very second day; if not it may remain for a week. Am- admissible.†

E GANGRENE OF THE SKIN.—In this curious affection, a ion of the skin, generally of the arm, becomes painful, and rtifies; becoming hard, white, and dry, and showing the the vessels with the blood dried up in them. It some- by the gangrene of a circle of the surrounding skin. The unknown, and the treatment must depend upon the cir- the case. The possibility that the disease may be caused

CHAPTER XIII.

SECTION I.—SCROFULA AND TUBERCULOSIS IN GENERAL.

DEFINITION.—Scrofula, or *Struma*, is a state of constitutional debility, with a tendency to indolent inflammatory and ulcerative diseases.

DESCRIPTION.—There are two varieties of scrofulous habits, which, although they agree in the main essential of constitutional debility, are yet totally opposite in many respects. In the *first* (or *sanguine variety*), the skin is remarkably fair and thin, showing the blue veins through it, and presenting the most brilliant contrast of red and white; the eyes are light blue; the hair light or reddish, the forehead ample, and the intellect lively and precocious. Sometimes, however, as Mayo observes, the skin is *dark* and transparent, and the eyes dark, although there is the same general characteristic of delicacy and vivacity.*

In the *second* (or *phlegmatic*) *variety*, the whole aspect is dull and unpromising; the skin thick and muddy; the hair dark and coarse; the eyes greenish or hazel, with dilated pupils; the belly turnid, and the disposition dull, heavy, and listless to outward appearance; although persons of this conformation will often be found to possess a clear, vigorous intellect, and powers of application far above the average. The great Dr. Johnson is an example.

In both varieties the natural functions are liable to be performed irregularly. Digestion is weak, the tongue often furred, and red on its tip and edges; the upper lip swelled, from a kind of turgescence of the mucous membrane, whenever the health is worse than usual; the appetite sometimes deficient, but more usually excessive, and attended with a craving for indigestible substances; the mucous membrane of the throat and tonsils flabby; the bowels torpid; the blood thin and watery;—its coagulum soft and small; the muscles pale and flabby; and the heart and arteries, as well as the intestines, thin and weak; the teeth decay early.

In the sanguine variety, the growth is generally rapid, and the bodily conformation good, as far as outward form is concerned—the limbs well made, the stature tall, and the chest broad. In the phlegmatic variety, on the other hand, the growth is often stunted, the chin short, joints large, feet large and flat, chest narrow, legs bent with rickets, and puberty retarded, especially in the females, who are liable to prolonged chlorosis.

CAUSES.—Scrofula being thus defined to be a peculiar state of the

* Vide Mayo's Philosophy of Living, 2nd ed. 1838; Carmichael's Essay on Scrofula, Lond. 1810; B. Phillips on Scrofula, Lond. 1846; Ancell on Tuberculosis, Lond. 1852; Latham's Lectures on Clin. Med.; Carswell, op. cit.; the works of Addison of Malvern; Wedl, op. cit.; Rokitansky, op cit; Hughes Bennett on Scrofula and Tuberculosis, ed. 1856; Lebert, Anatomie Pathologique, vol. i. 1857.

ction, it may be shown, *first*, that it may be *congenital* and ry; that is to say, that scrofulous parents may transmit ular organisation, and predisposition to disease, to their chil- It is believed that syphilis of parents occasions scrofula in , and that gin-drinking has a still more decided effect.

ally. The scrofulous habit, if not congenital, may probably be by any circumstance capable, directly or indirectly, of lowering energies; by poverty and wretchedness; meagre, watery, sufficient food; neglect of exercise; insufficient clothing; f cleanliness; habitual exposure to damp and cold, but most y by that want of fresh air and sunlight, which is the curse rowded habitations of towns.

ly. The scrofulous habit may be so intense, that the patient is with some of the diseases that we shall presently describe, in ll care. Or, on the other hand, actual scrofulous disease may er unless the health is first depressed by some other disease, carlatina, measles, the small-pox, or some other acute malady. r, everything that disorders the digestive organs may bring it m. It rarely breaks out before two or after thirty years of ough it may be called into active operation at any age by ases which lower the health. The time of the second denti- puberty are dangerous periods.

doubtful whether the English climate has more influence in than any other. It is true that the natives of warm climates, brought here, are apt to suffer; and so are the birds and ani- reign, and shut up in close dark cages; but these are special cts. The fact, however, is certain, that persons whose occupations ss to be exposed to the weather at all hours and in all seasons, nearly so liable to scrofulous disease as others, whose occupa- sedentary, and carried on in close, hot, ill-ventilated work- Pure air and sunlight often make amends for defects of food ing.

TULOUS DISEASE.—When the scrofulous constitution has been and circumstances have occurred to elicit an outbreak of actual a vast number of morbid processes may be set on foot, all of e included under the term of scrofulous disease. Their general acters are, that they are excessively insidious in their ap- ; seldom attended with acute pain, or with symptoms of nflammation; excessively obstinate; difficult to control by ; tending to the destruction of tissues by slow ulceration; tive in the processes of repair. Such are the diseases spoken e next Section; besides scrofulous *otorrhœa* and *ophthalmia*; *tarsi*; *eczema*; disease of *bones*, *joints*, *testicle*, and *mam- ad*; and convulsions and acute hydrocephalus during infancy.

SCLE.—The common doctrine is, that the characteristic mani- of scrofula is *tubercle*; a substance which is liable to be de- the lungs, lymphatic glands, areolar tissue, brain, bone, and f the intestines. Tubercular disease or tuberculosis is held

to be the sign of scrofula, *par excellence*. The question then ar what is tubercle?

1. *Yellow tubercle.*—The question seems easy at first sight. Wh ever a dull yellowish cheesy substance is found embedded in a tissue, it is usually called tubercle. But if examined under t microscope, this yellow matter is found to consist of amorph granules, and fragments and oil globules—showing pretty clearly th it is a something in a state of decay and degeneration.

Further research shows that *any* form of morbid growth may dec and be converted into a yellow-tubercular-looking, or putty-like ma in which the atrophied elements of the tumour are combined with f globules and cholesterine.

It is necessary to go back, therefore, and to ask what are the a stances whose degradation gives rise to the cheesy stuff, commo called tubercular? And the answer is, that any lymph exudat or plastic cell growth, or low inflammatory product may undergo th change, and be the first stage of cheesy tubercle.

2. *Miliary tubercles in the lungs.*—The lungs at their upper part ma be studded with little grayish, semi-transparent, millet-seed-like bodi from the size of a pin's head to that of a small pea. There seems n doubt that these consist of air cells, or clusters of them, blocked up b growth of epithelium; and that as the disease increases, these increa and multiply, occupy more tissue, and soften into the yellow cheesy stat

3. *Tubercular infiltration.*—The result of a low form of inflamma tory action, in which the changes of the epithelium in the air cell concur with cell changes and exudation into the intervening tissu which also degenerates. Whoever would see this to perfection, shou examine the lung of an ox which has passed into the second stage pleuro-pneumonia.

4. *Tuberculosis of lymphatic glands.*—This may begin as inflamma tion, acute or chronic, no matter by what cause provoked, or as mer chronic hypertrophy. In either case the abundant cell elements ma undergo necrosis and cheesy transformation.

5. In the *areolar tissue* tubercular deposit so called, general consists of a small lump of unhealthy lymph; perhaps a small cl colourized clot of blood; perhaps it may be merely inspissated pus.

So also in bone, in the dura mater, in the glands of the intestin any sub-inflammatory cell-growth, or plastic exudation, or growth epithelium, may be the starting-point, and may constitute the mater which forms the yellow cheesy tubercle.

From the foregoing, we may define tubercle to be an abort quasi-inflammatory cell-growth, incapable of development—and soon degenerating; and we may say that an accurate distinction betwe tubercle, and some forms of inflammatory cell-growth and pus, a some fibro-plastic growths in a state of degeneration, is impossible.

It is easy to believe that a low state of general health is accom panied with a tendency to active growth of some structures. Th is seen in the *acne* which infests the skin of strumous young perso

which may remain till the end of life (*cretification*).
rable cases it softens, beginning at its centre; an in-
filtration takes place at the circumference, and pus
ch is discharged by ulceration along with the softened
s process is too often attended with an increase of low
lymph exudation around the original focus, which
nes the same destructive changes. Similar unhealthy
place in the lungs, or intestines, or brain, diarrhœa, and
, until the organs affected be destroyed, and with them
individual. This is *phthisis*.

TREATMENT.—The general indications are to procure
healthy condition of the blood, and to protect the patient
g influences.

at length the general treatment of scrofulous persons
rite a treatise on general hygiène: we must content our-
iting at the most important points.

t should be nutritious, digestible, and abundant, con-
neral rule, of meat twice a day, good bread, green vege-
peas, mealy potatoes, cabbage, and the other *cruciferæ*,
eggs and milk, and a sufficient quantity of beer or wine
stion, without creating drowsiness or feverishness.*

thing should be warm, especially for the extremities, so
the cutaneous circulation, and prevent congestion in the
omen. Flannel should be worn next the skin, both in
mmer: in the former for direct warmth; in the latter to
accidental changes of temperature.

ercise of the muscles and lungs in pure open air is in-
All over-exertion of the brain should be avoided. The
may be trained; self-control inculcated, a thing very
atients who are as passionate and excitable as they are

is indispensable for the composition of flesh and blood.

(6.) Daily *washing and friction* o scrofulous as they are to every one el from taking exercise, friction is indis general so advantageous, that it has season is from the middle of August t object in using the cold bath is to pro quently, before taking it, the skin s the person who bathes should not be cooling condition from perspiration. plunge into the open sea early in the not only with impunity, but with adva best time for a weakly child, when the system is invigorated with a breakfast. a short immersion renders the surfa Warm salt baths are very useful.

(7.) *Tonics.*—It follows from our d medicines most likely to be of service a firmer, healthier composition to the flesh which deserves notice is the *cod-liver oil*, of checking emaciation are now happily w in any scrofulous disease, and in any case i flesh, in as large quantities as the stomach recommends it to be given just as the patien by this means all chance of nausea is preven light yellow sweet oil, prepared at home or land. Any other fish-oil that is not too ra foot jelly, blancmange, isinglass, good meat, F. 196, or a

ed vinum *ferri*, and the aromatic mixture of the Dublin
ria—to the more astringent and stimulating chloride,
The sulphate of zinc, the nitro-muriatic and sulphuric acids,
bitter substances, are also useful.

i-strumous remedies.—There are some medicines which have
pute from their supposed power of improving the condition
d; and possibly from their solvent power over morbid de-
ch are iodine and its compounds with potassium or with
liquor potassæ; lime-water; the combination of corrosive
with tincture of bark; the chlorides of barium and of lime;
or decoction of walnut leaves. Of these remedies, the pre-
f iodine have the greatest repute, F. 88-95. The waters of
are good during the winter.

are often of great service under certain conditions. They
ally indicated if the patient complains of heartburn or great
if the tongue is very red, or if there is a sinking and craving
on after meals, or acid eructations, or other dyspepsia, or
ing urine. F. 77.

rolla, F. 84, 85, seems to improve the powers of nutrition
, and may always be given in cachectic diseases for which
palpable cause. Sweetwort is as good.

Purgatives are often necessary to sweep away the refuse left
perfect digestion; and besides it is fair to believe that the
local disease will be greatly lessened by a pure state
d. In some cases the gentlest alteratives, F. 65, in others,
ients are required; whilst in the case of *active* strumous
skin or mucous membrane, of a congestive or ulcerative
h foul tongue, big belly, and loaded urine, the greatest
enefit is sometimes derivable from efficient doses of calomel
imony; or more especially of that admirable compound of
nd polychrest salt which has obtained repute as a specific,
, 41. Of course we exclude cases in which a red tongue
d state of bowels indicate a tendency to ulceration of the in-
nd in which soothing absorbent remedies, F. 79, are indicated.

Anodynes.—Pain, when violent, must be relieved by opium or
dynes; and the extract of conium, in regular doses thrice a
be of service when there are intractable ulcers.

ECTION II.—PARTICULAR SCROFULOUS DISEASES.

SKIN is particularly liable to suffer from pustular and sup-
malaties; especially behind the ears, on the scalp, and
mouth, nose, and eyelids. These eruptions are generally
.

ment.—The general health must be attended to, according to
ing rules, and the local disease be treated by the frequent
p and water, and the application of the ointment of oxide of
d white precipitate or nitrate of mercury, or the black wash.

perfectly, and does not get well till
destroyed by ulceration. 3rdly. A
lymph may form in the cellular tis
causes abscess, and then sloughs out.

III. Disease of the Lymphat
is the commonest of scrofulous or
primary, or may be created by som
mucous membrane. It may begin with
or with an indolent and painless deposi
glands may remain for years station
length, from local irritation or disorde
abscesses form between them and the
the abscess is opened, it contracts and h
as before. But more generally all the
comes infiltrated, just as the lung does
to the gland, and ulcerates, healing aft
puckered cicatrix, but not till the whol
puration. These swellings have been
pressing the tracheal or cervical vessel
We would speak, did space permit,
enlargement of lymphatic glands with t

IV. Scrofulous Ulcers may be t
excoriations of the skin that have bee
formed by the ulceration of glandular a
which case they sometimes destroy exten
tissue, and may kill the patient by exh
and useless if he recover. Or they ma
base, thick everted edges, a copious form
deposit of unhealthy lymph in the ad
with the granulations, is liable to fits o
pain. Or they may take the charac
ulcer, spreading

before the skin has become red and thin. 4thly. Indolent ers, some time after opening, may be treated with injections of lotion, as of zinc or copper lotion. Ulcers may be treated on the principles laid down in the sections on weak and irri- ulcers. Poultices and emollients are seldom of service. The thin overlapping the edges of an ulcer or abscess, which is inclined may be removed by a touch with iodine paint. Such are the points worthy of notice in the local treatment of scrofulous and ulcers.

TABES MESENTERICA, or MARASMUS, consists in a tubercular of the mesenteric glands, and of the follicles of the intestines, ly similar in its course and phenomena to the same disease in the

glands. The diseased intestines inflame, adhere together, and so that openings form between different convolutions; and on ation the peritonæum is found as thick as leather, and the intes- esembling a collection of cells rather than a simple tube.

ptoms.—Emaciation and voracity, owing to the obstructed of the chyle; the belly swelled and hard; the skin dry and ; the eyes red; the tongue strawberry-coloured; the breath foul; ds clay-coloured and offensive, sometimes costive, sometimes ely relaxed. The patient of course dies hectic, although he ists wonderfully long.

tment.—Animal food and other nutriment given in small quan- at short intervals; mild mercurials to amend the intestinal ns, especially the combination of corrosive sublimate with tinc- f bark, F. 87; tepid salt bathing; stimulating liniments to the n; change of air; and the cautious administration of the anti- ous remedies before mentioned, especially the cod-liver oil.

presents enlargement of the mesenteric glands from a scrofulous patient.

to signify, not *any* kind of s
largements as are caused by n
understood certain masses of
cessively, and abnormally. (
Thus in the definition of tu
they are composed of a living
if of natural tissue, yet develo
2ndly. That they grow indepen
grow with appearance of inheren
maintenance of the rest of the
and with no seeming purpose."
body, and borrowing from it the
its life, the tumour grows, or ma
to peculiar laws."*
Each sort of tumour depends, n
tional vice. But the nature of tha
dies are equally unknown; for t
that is influenced by any medicine
CLASSIFICATION.—The true b
growths is their structure; and th
naked-eye and microscopical charac
toms, and subsequent history of e
tively studied.
A large group of tumours are c
matter, in some stage of developm
rudimentary cell-growth, and perf
group includes the *fibro-plastic*,
gelatinous tumours; which are co
p. 24), which increase in bulk, v
tissue; and in which a great varie
Many pathologists think that canc
to this group. Rok

oup is composed of new and independent development
, more or less perfect.
blood-vessels.
distinguished by the presence of *cysts;* although cysts
rith in most tumours.
sists in the local overgrowth of *fat tissue.*
consists of enormous production of *epithelium.*
of black pigment.
distinguished by certain peculiarities in its cell elements;
y its fatality. This is the group of *cancer.*
ll tumours which had the fatality of cancer were consi-
ng to a group apart, and were called *malignant;* whilst
were called *benign* or *innocent.*
benign, it is assumed that they originate in a sort of local
ation. That they are *homologous*, or *homœomorphous*, or,
ds, identical with, some of the normal tissues of the body.
ay be continuous with normal tissues of the same sort, but
d, discontinuous, and not infiltrated amongst a variety of
. That there may be many in one individual, but usually
tissue. That they are perfectly compatible with a high
th. That they have an uncertain period of increase, after
ay remain stationary for an indefinite time, or may undergo
fatty or earthy degeneration. That they may, by their
ssion, cause œdema and paralysis, or obstruction to various
ay inflame and suppurate; or may undergo ulceration or
and so may seriously impair the health; but that all these
ms are local and accidental, and cease if the tumour be re-
that if effectually removed, there is no return, either in
in any other place.
malignant, on the contrary, it is said that they possess
g marks: 1. They are of constitutional origin. 2. Their
generally rapid. 3. They increase constantly; 4, are at-
pain; 5, return if cut out; 6, are liable to be diffused
y from increase of the *materies morbi;* or 7, are liable to
points, from being absorbed from one part and deposited in
they are attended with cachexia; 9, they resist all treat-
they infiltrate every tissue in their vicinity; 11, soften
12, ulcerate outwardly; 13, invade the lymphatic glands;
rologous in structure, that is, resemble no tissue naturally
e body; and lastly, after a time prove fatal. The only
ssing all these marks is cancer.*
is a third, intermediate class, of *semi-malignant* or *cancroid*
luding those which have some, but not all of the vital cha-
f cancerous growths; as well as those which (like the
resemble cancer in their coarse appearances, though not in
ructure.
ith, there is no absolute line of demarcation between ma-

* Paper on Cancer, by R. Druitt, Association Journal, Jan. 1854.

lignant and non-malignant growths. All *tumours are con*
All are liable to return after extirpation. Some varieties
and fibro-plastic and cartilaginous tumours may not only
removed, but may invade many internal organs. There is
which in some individuals, or under some circumstances, ma
play at least ten out of the fifteen signs of *malignancy*. B
this, it is absurd to erect the malignant into a separate class,
innocent tumours of the same structure. It is like puttin
fatal cases of a disease into one class and the unfatal into ano
modern plan of putting *recurrent* tumours into a separate
equally absurd. Any tumour, if extirpated, is liable to be fo
one of a worse sort.

SECTION II.—THE FATTY TUMOUR.

THE FATTY TUMOUR (*Lipoma*) is *composed* of genuine f
that is, of oil-cells, rounded or polygonal, packed in the m
natural areolar tissue. Such tumours are contained in a fi
sule, in which their blood-vessels ramify, and which sends
throughout their substance, dividing them, more or less c
into lobules.

In *outward characters* they are soft, painless, and lobulate
just like fat.

Their most usual *situation* is the subcutaneous cellular tis
trunk, especially about the back of the neck and shoulders,
may extend between and under fasciæ, deep amongst the mus
neck, trunk, or limbs. They may even be found in parts wh
exists naturally, as the scrotum or eyelid.

In number this tumour is generally single; its growth i
may attain enormous bulk, even 70 lbs.; but causes no inco
save what arises from its weight and situation; and is li
process of degeneration, except that it may possibly become
and adherent, or hardened by the development of fibrous tissu
may ulcerate or slough out.

We meet with the name *recurrent fatty tumour* in the P
Transactions,* and read of a fatty tumour whose fibrous stro
the encroaching characters of "malignancy."

It may by its softness be mistaken for chronic abscess o
tumour; but the *tactus eruditus*, or puncture with a groov
will distinguish the difference.

Treatment.—The liquor potassæ has considerable influen
ing the absorption of fat, when there is a universal tendency
or even when there is a partial overgrowth of fat in some p
body; where it is an exaggeration of the whole fatty tissu
region and not a true circumscribed tumour. Sir B. Brodi

* Dr. G. Harley, p. 224. Report on fatty tumour of sole of
infant.

ich local hypertrophies of fat in the neck more commonly than elsewhere, and gives the case of a servant, in whom such an overgrowth was aggravated by iodine, and cured by liquor potassæ. The dose is a mid drachm, thrice daily in table-beer. But neither this nor any ther medicine has any effect on the true fatty tumour.

Sometimes a fatty tumour on the cheek has been caused to waste in uppuration by means of a seton passed through it; but, for most ases, extirpation by the knife, after the manner described in the last 'art, Chap. II., is the only remedy, and an effectual one; for this of ll tumours is the least likely to return.

ECTION III.—THE FIBROUS, PAINFUL SUBCUTANEOUS, FIBRO-CELLULAR, FIBRO-PLASTIC, FIBROID, FIBRINOUS, FIBRO-NUCLEATED, AND COLLOID TUMOURS.

1. The Fibrous Tumour (*desmoid tumor*) is composed of fibrous issue, identical with that which forms the normal tendinous structures f the body, and which it perfectly resembles in naked-eye appearances. n many tumours the fibres are arranged in bands or loops, or perhaps n concentric circles round numerous centres; in others they are intricably matted together. Some are vascular and pinkish, but the majority almost destitute of blood-vessels. Microscopically they are een to consist of fibrous tissue, which when rendered transparent by cetic acid, usually reveals numerous nuclei scattered amongst the ibres.

The most frequent *habitat* of these tumours is usually said to e the womb. But the so-called ibrous tumours of this part consist n reality of unstriped muscular ibre. Fibrous tumours are common in connexion with the periosteum, especially about the aws, or may grow in the interior f bones; in the subcutaneous ellular tissue; in the breast, and particularly in the nerves, where hey receive the name *neuroma*.

On examination these tumours re usually firm, free from tenderness, smooth, oval, or pyriform; lightly lobulated; of slow growth; lasting any number of years, and ttaining almost any size; generally single as to number, or, if multiple, affecting but one and he same organ.

Their origin is usually quite spontaneous, and cause unknown

* Section of "fibrous tumour" from the uterus, treated with acetic acid.

sometimes they follow an injury; but even then the reason quite unknown.

Of the degenerations this tumour is subject to, the com is *calcification*, that is, infiltration with earthy salts, by whic of it are converted into a stony mass. Cysts also, filled w rous fluid, may form in the interstices. Such a tumour may i soften, suppurate, and slough out entirely or by degrees; adhere to the skin over it, and cause it to ulcerate by distens may slough, or may throw out livid bleeding fungous protrusion

Extirpation is the only *treatment*; after which the patient i comforted with the probability that there will be no return of t ease in the same place, or elsewhere.

Yet, as we have before said, cases occasionally happen in w fibrous tumour has returned again and again, after apparently th extirpation, and has been excised five or more times, till at last manent cure has been obtained. In any such case of recurrence and free extirpation should be resorted to; and the iodide of pot be administered. In other rare cases a fibrous tumour, after re extirpation, has been succeeded by a cancerous growth; whilst in still rarer cases, not only does the fibrous tumour return on ab excision, but invades the lungs or other internal organs.

II. The PAINFUL SUBCUTANEOUS TUMOUR, of Wood, is a body, rarely larger than a pea or coffee-berry, composed of fibr sue, situated under the skin, generally single, generally s women, subject to fits of most excruciating neuralgic pain, an the cause of hysteric and other spasmodic affections. Hi anatomists have failed to detect, on dissection, any connection b these tumours and the nerves; so that a distinction must be dr tween them and the *neuromatous* tumours, which are generally m affect men rather than women, and consist of small fibrous t embedded in the sheaths of nerves. Extirpation is the remedy.*

III. The FIBRO-CELLULAR TUMOUR is composed of the c areolar tissue of the body. On a section it displays bands of firm fibrous tissue, intersecting a softer, yellow, gelatinous-looki stance, infiltrated with serum. Microscopically, the charact those of fibrous and filamentous tissue, in a more or less compl of development. The most frequent seats of this tumour are which the fatty tissue is not found: as "the scrotum, or lab the tissues by the side of the vagina, the deep-seated interm spaces in the thigh, and the scalp." But the same tissue likew stitutes, says Mr. Paget: "1st. Nearly all the softer kinds of such as the mucous or gelatinous polypi of the nose; and the p the external auditory meatus. 2nd. The various cutaneo growths, such as occur in the scrotum, labia, nymphæ, clito more rarely in other parts; and, as hardly to be defined aw

* See the paper by Mr. Wood, who first accurately described an this tumour, in Edinburgh Med. Chir. Trans. vol. iii.; Lond. Med. Ga p. 59; Paget's Lectures; Wedl. op. cit. p. 400.

these, the warty and condylomatous growths of skin; and 3rdly, the outgrowths of scars, the cheloid tumours as they are named." When occurring as distinct tumours, they are felt as soft, elastic, painless masses. Their growth is usually quick, though a sudden increase of size may be due to serous infiltration, rather than to increase of tissue. They may attain a very large size; may accidentally slough or ulcerate, but can be radically cured by excision.

IV. The FIBRO-PLASTIC TUMOUR of Lebert (*sarcoma*) is composed apparently of plastic lymph permanently arrested in its development into areolar tissue. There are two varieties of naked-eye appearances which are often combined in the same specimen.

1. The soft variety has a great resemblance to encephaloma, being quite as soft, though more elastic, and not so readily torn; yielding, when cut, a clear serous, and not milky juice; and having altogether the character of flabby granulations, such as are found surrounding carious bones.

2. The harder variety, or real sarcoma, is of firm consistence, like that of muscle, or of *carnefied* lung, or rather of kidney; but not so firm as the fibrous tumour; on a section it appears homogenous, and finely grained; its colour varies from reddish yellow to a deep fleshy red; these tints alternate in patches, and are mixed with spots of ecchymosis; it is often intermixed with fibrous bands, and contains many blood-vessels.

The microscopic elements of the fibro-plastic tumour are—1. Fibro-plastic cells, spherical or ovoid: with pale cell-wall, well-marked nucleus, and nucleolus in the form of a small dot. 2. Cells elongated into oat-shaped or pyriform bodies; pointed, or branched, and losing their nuclei. 3. Free nuclei, some elongated; and small globules. These elements are depicted at page 24. 4. Mother-cells; large oval

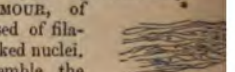
* Myeloid cells from a fibro-plastic tumour of the upper jaw, removed by Mr. W. Fergusson, 24th Nov. 1855. In colour and consistence it exactly resembled human kidney.

† Imperfect areolar tissue, and large cells containing fat globules from a fibro-gelatinous tumour of the calf of the leg, drawn from nature. See a description of the same tumour, Pathological Trans., vol. v. plate xvii.

bodies from ·001 to ·003 inch, enclosing from two to ten or te fibro-plastic nuclei. These cells are called *myeloid* by Paget, from resemblance to cells found in the marrow of fœtal bones; and tumours in which they are formed he also calls *myeloid*. 5. Fibr matter, more or less perfectly developed into tissue, inclosing cellular elements; sometimes very scanty, sometimes abundant, and gelatinous (*fibro-gelatinous*, or *fibro-colloid tumour*). 6. W developed areolar tissue enveloping the tumour, and forming bound to its various lobules.

In external characters, fibro-plastic tumours are usually sm lobulated, and globular. They may be situated in the skin; in subcutaneous, or submucous, areolar tissue; deep amongst the mus (especially of the thigh), in or upon bone, especially the maxilla; on the dura mater; or in the mamma or other secreting glands, or the lymphatic glands. They generally, but not always, grow slo they may attain enormous size; may undergo calcification; or inflame and ulcerate, or slough, and so prove fatal. They usu are single; may occur at any age; they sometimes seem to arise fr a syphilitic taint. As regards origin, some seem to follow an obs inflammation, which has produced exudation into a lymphatic gland the testis. Others are of independent spontaneous or unknown or If extirpated they are exceedingly apt (much more so than the fi tumour) to return in the cicatrix, but very rarely in any other p yet they may do so, or may be *diffused* over the system in the manner that cancer is. The tumours most likely to become *malignant* are those of spontaneous origin, which yield most var of embryonic cell-forms. Fibro-plastic elements are also foun abundance in glandular, and most other rapidly-growing tumours. *treatment* consists in extirpation, repeated if the disease returns; the prolonged use of iodide of potassium. Some fibro-plastic tum soften down and become converted into the thin purulent and contents of scrofulous abscess; a few disappear spontaneously.

V. The FIBRO-NUCLEATED TUMOUR, of Hughes Bennett, is a tumour composed of filaments infiltrated with abundance of naked nuclei. In outward appearance it may resemble the fibrous, or fibro-plastic tumour, or cancer; but microscopically mined the presence of nuclei, instead of cells or fibres, distinguish from the former two growths, and the absence of cancer cells from last. Its clinical history is identical with that of the former tum



VI. The FIBROID TUMOUR is one in which the cell elements developed themselves into a coarse resemblance of fibres.

VII. The FIBRINOUS TUMOUR is composed of almost structu decolorised blood-clot, and is the result of extravasation of blood forms a soft tumour, and may generally be distinguished by its hi and by its sudden origin. A tumour formed of extravasated

* Fibro-nucleated tumour. From an ass.

may be a complication of most tumours which have attained enormous size; sometimes exists alone.*

VIII. COLLOID, or GELATINIFORM MATTER is a substance closely resembling glue, or jelly, of various degrees of firmness and transparency; and is often found in cysts in the thyroid gland, and in the ovaries and prostate. The writer has several times found it in the substance of fibro-cellular tumours; and it may be found amidst the products of chronic inflammation of the pleura and peritonæum. Moreover, a glue-like matter is a characteristic of one form of cancer. (See *Colloid Cancer.*)

IX. RECURRENT FIBROID TUMOURS.—*Any* tumour may recur; and it is almost childish to give a name from their property. But it may be noticed, that those tumours are most likely to recur which attain largest bulk with most imperfect development—that a tumour of unformed nuclei is more likely to recur than one of true fibrous tissue; and that tumours which have been cut out and removed five, six, or seven times, have in each reappearance presented a more immature and "malignant" state of their elements.

SECTION IV.—CARTILAGINOUS AND OSSEOUS TUMOURS.

I. The ENCHONDROMA, or cartilaginous tumour, consists of round masses of cartilage, embedded in fibrous membrane. It may be of various degrees of firmness; almost as soft as the vitreous humour, so soft as to be mistaken and punctured for ganglion, or as firm as ordinary cartilage. It consists microscopically of cartilage cells embedded in an intercellular hyaline substance; but there are very many varieties, not only in the quantity, consistence, and transparency of the intercellular substance, but also in the number and arrangement and size of the cells, and of the nuclei. Generally speaking, the cells are numerous, and loosely connected to the hyaline substance. They are round or oval; from $\frac{1}{\text{th}}$ to $\frac{1}{\text{th}}$ inch in breadth; and the cell-wall may be completely distinct from, or inseparably blended with, the intercellular substance. The nuclei are single, sometimes double; round, or oval; rendered paler by acetic acid; with one or two nucleoli; some shrivelled or full of oil-granules; some throwing out projections, like those of cartilage in process of ossification.

† Microscopic characters of enchondroma. Nuclei granular.

* See Canton, Pathological Trans., vol. xiii. p. 238.

Chemically it consists for the most part of phosphate of lime, and of a peculiar variety of gelatine, called *chondrine*, which is extracted by boiling in water from the temporary cartilage of the fœtus, and from the permanent cartilage of the adult, but not from the adult bone or tendon. It differs from common gelatine, in containing less oxygen, and in being precipitable by alum, acetate of lead, and sulphate of iron.

In external character, cartilaginous tumours are firm and smooth, usually somewhat nodulated, sometimes hard, sometimes so soft as to be mistaken for cysts. Their usual situation is on or within the bones, particularly those of the hands; and they may be developed either within the bones, which they then cause to expand into a thin shell, or else from their surface, beneath the periosteum; in which case they usually have, like other tumours in the same situation, a skeleton of light papery plates, and spicula of bone shooting throughout their substance, as represented in the next cut. Or they may become ossified, from internal independent centres of ossification.

But besides the bones, enchondroma may form in the glands, as the testicle, mammary, and particularly the parotid. It may form isolated moveable tumours in the subcutaneous tissue, and may be found in the lungs. It may likewise be combined with the fibrous, fibroplastic, colloid, and cystic growths, or with cancer.

The growth of cartilaginous tumours is usually slow; but this is subject to great variety.

Thus, in one case, related by Mr. Frogley, a tumour of this sort, growing upon the femur, attained the circumference of three feet in five years; another, twenty inches in eleven years; another, mentioned by Mr. Paget, acquired the circumference of a man's chest in three months from the time when it was first noticed. The articular surfaces in the neighbourhood are not affected, nor is there any adhesion or infiltration of other tissues. But, after an uncertain time, the cartilaginous tumour may undergo fatty or earthy degeneration, as in the case of a small nodule the size of a walnut, removed by Mr. Walton from the subcutaneous tissue of the forehead, in which the writer found half the tumour degenerated into a yellow, cheesy mass. Moreover, the hyaline substance may soften down into a stuff like pease soup, as in another specimen from the vicinity of the parotid which Mr. Walton sent to the author, and which was converted into a mass of cysts, with fresh lobules of cartilage growing into them. Such cysts may ulcerate and discharge their contents, giving rise to great constitutional irritation and exhaustion.

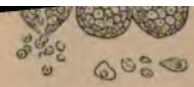
* Enchondroma of the hand. From a cast in the King's College Museum.

…us tumours are more frequent in early life. They are …le and hereditary; and although, as a general rule, they … when thoroughly excised, yet to this rule there are many … A case is narrated by Mr. Paget, in which a cartilaginous …uled along the lym- … the testicle to the …nferior, and into the …t vein: masses of car- …so found in the lungs.† …s TUMOURS are so con- …d in connection with …at it will save repe- … refer our readers for …f them to the Chapter …s. But we must say … a distinction is to be …en tumours containing …ous, and others which …*calcified* or impreg- …morphous earthy salts. …se osseous tumours are …the hypertrophy of ex- …; and 3, others by the …f pre-existing fibrous, …, or cartilaginous tu- …en these are attached to …ey constitute *exostoses*; …y tumours, formed by …ion of the other kinds, …olated in the soft parts. …*osteosarcoma* was for- … to signify any tumour …one was mingled with …; as, for example, the …ma, or fibrous tumour, …ring, and cancerous …inging from the sur-

…TION V.—GLANDULAR AND VASCULAR TUMOURS.

…DULAR TUMOURS are formed by the development of a tissue …dist of secreting glands. Such tumours are most common …e breast, where they are known by the terms *chronic mam- …r*, and *imperfect glandular hypertrophy*; but they may

…tion of enchondroma.
…n Cancer, &c., translated by West, Lond. 1840; Lebert, Phys. …; Paget, Lectures, Med. Gaz. 1851; Frogley, Med. Chir. Trans. …get, ib. vol. xxxix.



If the contain
epithelium m
the fibro-pla
these tumour
inflammatory
degeneration. This disease may disapp
remain stationary; or it may enlarge, di
trude as a bleeding fungous mass, and
exhaustion. It is sometimes traceable to
health, but more frequently not. The iod
sometimes seem to delay the growth of th
requires extirpation. Even then it is exce
cases are on record of five or six succe
patient, followed by renewed growth of the

II. VASCULAR TUMOURS are composed
containing blood, and will be more conveni
ter on the Arteries.

SECTION VI.—CYSTIC T

These are tumours consisting of a sac, co
stances. They may arise in three ways
definite cavities in the meshes of the comm
the dilatation and growth of obstructe
3. By the independent and erratic developm
become exaggerated into cysts; or of isolat
which fill with secretion, but are unprovid
extravasation of blood, and the disappearanc
separation of the serum from the fibrine.

I. SEROUS CYSTS.—Of the simple cysts,
containing serum. They may occur in al
or morbid; in the interm

This, and the preceding kind, sometimes heal and collapse puncture, sometimes they require to be dissected out.

FIAL CYSTS, or GANGLIA. See Part IV., Chap. III.

D CYSTS are formed by the obstruction of *excretory ducts*, *glands*, or by the abnormal development of portions of it ducts. Under this extensive division we may include ts, or *ovens*; which are formed by the obstruction, or by l development of follicles, whose inner surface secretes ıbaceous matter, with, perhaps, hair; and such cysts are ly under the skin, and in the ovaries, but in the skull, the ny other parts. Teeth (which, it will be remembered, he dermal, or exo-skeleton) are also found in these cysts s, as well as in cysts attached to the jaws. Cysts in the e testicle, containing spermatic filaments, or in the breast, ilk; the cysts formed in mucous membranes, and ranula, d under this head. The contents of these cysts, which at presumed to be identical with the natural secretions of the h they are formed, become greatly altered by time. Solid ; viscid honey-like fluid; or colourless pellucid mucus, liffe.ent instances.

CND CYSTIC TUMOURS; such as occur in the ovaries, and the chorion; formed, by the exaggerated development into cells of which these structures mainly consist.

FEROUS CYSTIC TUMOURS (*Sero-cystic Sarcoma*) are com-, having solid fibro-plastic or glandular growths project-. (See the Chapter on the *Female Breast*.) They may two modes,—either as tumours, in which cysts are after-ped; or as cysts, to which the solid growth is superadded In either case, the history may be divided into three stages. e is the formation of cysts, possibly single; usually very Secondly, there is the growth into the cysts, from some walls, of vascular tumours, composed of fibro-plastic cells, dimentary gland structure. The intracystic growths in

lymphatic ganglia enlarge and be
deposit; and muscle, bone, and every other ad
But whilst the deeper parts are enlarging, the
of foul and extensive ulceration. It cracks
sanious fluid, which, mixing with the epide
When this is detached, a wide ulcer is brought
there is formed a deep irregular excavation i
thin ichor, surrounded by fungous warty gro
base of hard adherent and infiltrated skin. Th
may be destroyed; or the bladder, rectum, an
may be converted into one huge cloaca. If ex
nearest lymphatic ganglia enlarge, and form a
ginal. The constitution may be apparently so
continue so till it begins to be worn by the incess
and irritation of the ulcerated surfaces, the absor
and the interruption to various functions which
disease be situated near the mouth, the anus,
apparatus. Secondary epithelial deposits have b
lungs, heart, and nerves.

Causes.—Men are more subject to this disease
rare before 40;—but of its predisposing and exci
is known than may be summed up in three stat
some few instances, hereditary predisposition m
inasmuch as, in $\frac{6}{165}$ instances, Mr. Paget found t
the patient's family had suffered from this disea
this number, as Mr. Paget observes, although sm
referred to chance. 2. Constantly repeated loc
have some small share in producing this disease;
that the smoking of short pipes is a cause of epit
that phymosis causes, or at least predisposes to,
When it attacks the trunk or limbs, it is almost
some old scar, or ulcer. The frequency of t
sweepers' cancer of the

isease. The malady is far more liable to return after
more rapidly and certainly fatal on the lip, tongue, or pe.
e trunk or limbs.
e seen that *phagedænic* epithelioma has close affinities with
its tendency to spread; to invade and infiltrate all tissues
y; to affect the lymphatics; and to return after excision,
inasmuch as it is more capable of being excited by external
not attended with so early or obvious derangement of the
more curable by excision; homologous in its elements, and
except in the rarest possible instances, to be diffused over
gans.
ment.—The only measure worth speaking of is very early and
ation by the knife, followed by repeated and wide excision of
whatever within the sphere of the malady, if it returns; or
ation with caustic after the manner described under the head
and *Cancer*. And extirpation is still to be advocated even in
re the disease has made great progress, and where the lym-
s affected, because although it must be confessed that the
almost sure to return, and ultimately to prove fatal, yet it
though but for a time, a disgusting and irritating ulcer, which
the patient's spirits, and exhausts his vital powers. In other
the general and local treatment is that of cancer.*

SECTION VIII.—MELANOSIS.

TION.—The word *melanosis* has been applied indiscriminately
s containing notable quantities of black pigment.
d is a thing of frequent occurrence in the animal body. In
eals it appears earlier than blood or vessels; and it may be of
mposition and proper-
ferent cases. But it is
und in the form of the
epia-coloured granules,
give the colour to the
at of the eye, and to
n dark persons, and the
the aged. These gra-
y be free, or collected
es, with a cell-mem-
und them; or may be
any morbid growth

†

The chemical composition is not settled; but pigment

full account of this disease, consult Hannover, das Epithelioma, &c.
832.
en represents a portion of a very tough fibrous tumour, loaded with
from an old bay pony of Professor Simmonds, of the Royal Veterinary
The author begs to express his acknowledgments to Professor Sim-
r many opportunities of studying morbid growths in the lower

from the lungs has been stated to contain from 80 to 90 p
of carbon; to resist sulphuric acid; and to be converted by t
acid, and by chlorine, into a brown substance resembling ulmi
The surgical relations of pigment are these,—1st. It is of
met with in *degenerating growths* of any kind. 2ndly. It is of
occurrence in those small patches of hypertrophied skin call
3rdly. It is often abundant in *cancer*; so much so as to con
variety, called melanotic, or black cancer. 4thly. There is a
diathesis in which large quantities of pigment may be deposit
filtrated through many organs in the same individual, either al
conjunction with fibrous or fibro-plastic elements. This is a v
mon malady in old bay and gray horses. But although these
may pervade the entire body, and occasionally soften, they hav
malignity. See *Melanic Cancer*.

SECTION IX.—CANCER.

DEFINITION.—Cancer is a disease evidenced by the develo
peculiar cells, called cancer cells, or of their nuclei. These,
with a liquid, or semi-liquid substance, called the cancerous
contained either in a *stroma* of new fibrous tissue, or in the
of some other already-existing tissue, constitute a cancerou
The common characters of all cancerous growths, are the fi
racters of malignancy which we have given at page 99.

CANCER CELLS.—These, which form the characteristic e
cancer, are, in their best examples, regular spheres, about $\frac{1}{70}$
diameter, with an oval excentric nucleus, occupying the half or
the interior, and containing one or more large nucleoli. Th
of the cell is pale and fine—that of the nucleus, bold and well
the contents of the cell finely granular. Acetic acid renders
pale and transparent, and the nucleus more distinct.
But from the typical form there are many variations,—for t
cell may vary in size from the $\frac{1}{700}$ to the $\frac{1}{5000}$ of an inch; in
may be ovoid, triangular, fusiform, or elongated into one or mo
exhibiting a much greater variety of form than any other kno

* Cancer cells traced by the author with the camera; magnified 200 d
a, nuclei; scale of ·001 inch.
† Typical Cancer cells and nuclei from nature.

be large mother-cells, containing three or more nuclei
all complete cells; or there may
abundance, which have not yet
-wall developed upon them, to-
h abundance of molecules and

lls may deviate from the common
, through want of development;
smallest and least complete cells
the quickest growing cancers of
riety, and it may be very difficult
ish these from fibro-plastic cells.
affirmed that small old slowly-
ard cancers, yield the most per-
rge rapidly-growing cancers the worst developed specimens
lly. Cancer cells present other varieties depending on degenera-
dy infiltration; for cancer, like all other tumours, may decay
llow-cheesy tubercle-looking mass. This was described by
a distinct variety under the name *reticular cancer*.
juice which may be squeezed from the freshly-cut sur-
ry cancer, and should be taken up for examination without
is a rather milky liquid, which mixes readily with water into
n.

roma, or framework of cancer, may either be the natural
glandular, or other tissue, or else a new fibrous tissue, of
egrees of firmness, and intermixed in rapidly-growing tumours,
form cells, and other common fibro-plastic elements. Neither
lymphatics have been found in cancer.

TIES OF CANCER.—1. The type and model of cancer is that
commonly called *soft cancer*, *encephaloma*, or *fungus medul-*
d which is characterised by very great abundance of cells,

-cells, and other varieties of cancer cell, drawn by Dr. Lionel Beale.
r cells in their stroma. *b*, some cells loaded with oil, others with
pigment. Drawn by Dr. Lionel Beale.

contained in the meshes of a most delicate fibrous tissue. It is, name implies, of about the consistence of brain, or of very firm mange. When cut, it is seen to be of a whitish-yellow colour, ish, if vascular; on pressure there exudes from the cut su plentiful *juice*, containing abundance of cancer cells, or nuclei.

In external characters the soft cancer usually forms a tumour growth, rounded, smooth, more or less lobulated, softer in som than in others, not tender. In its earlier stages it may be circum and separable, though it may extend long distances in the inter muscles or other organs; in its latter it is usually adherent, with surrounding parts, and not moveable. If situated near face, it may, by the rapidity of its increase, cause the skin to u

then, relieved from pressure, it grows with greater rapidity, th up huge fungous masses, from whose surface there oozes a thin fluid. This, however, is not peculiar to soft cancers, but com any other rapidly-increasing growth.

2. The *hard cancer*, or *scirrhus*, or *carcinoma*, has, as its na plies, a much firmer consistence than the preceding variety, w due to the presence of a dense fibrous tissue; but there may b gradation, in this respect, from a scirrhus as hard as fibro-carti the softest and almost diffluent encephaloma. In well-marked ex a hard cancer cuts crisply; the cut surface shows irregular in ing, firm, whitish fibrous bands, with a softer grayish or yellow in the interstices, from which the cancerous juice can be made t by pressure. In outward character it presents itself as a firm

* Soft Cancer of the Breast, in the state known as *fungus hematodes* the King's College Museum.

ally nodulated tumour. This, in cancer of outward part. , becomes adherent, is subject to severe pain of a stabbing ng character, distends the skin, ulcerates, and forms a more vated ulcer, with hard, fungous, everted edges, constant charge, and se- g pain.

Melanosis, or ncer, is cancer the soft variety, with pigment. ary disease, it occurs in the bout the eye. a time it may, ther varieties of ade every organ y. For example, reported by Mr. f Manchester, it in skin, areolar cles, pleura, lungs, heart, liver, mesentery, spleen, kidneys, .*

our, Prov. Med. Journ., 1850, p. 225; Fawdington on Melanosis, Lond. must be admitted that we know not how many of reputed cases of are cancerous, and how many consist of pigmentary deposit without

ule of black cancer in the true skin.
cancer impregnated with pigment. From a bay mare.

4. *Colloid*, or *Gelatini-form*, or *Alveolar Cancer*, is a peculiar growth, composed of a *stroma* of thin membranous or fibrous material, so arranged as to form circular loculi, resembling in this respect the pulmonary tissue, and filled with globular masses, composed of concentric layers of that structureless material which we have described as colloid matter.

The loculi, or rounded cells, are visible to the naked eye on a section, and may vary from the size of a pin's point to that of an egg. The colloid matter seems to differ much from other animal products, and to resemble the jelly of the umbilical cord, or mucus, or the tissue of the acalephæ and medusæ. Its animal basis is said to contain only 7 per cent. of nitrogen.

The rounded masses of gelatinous matter contain granules and nuclei; and the larger masses contain abundance of smaller ones, into which their substance appears to have divided and developed itself after the manner of the growth of cartilage. The gelatinous matter is arranged around these granules and nuclei after the manner of cell-growths.

The question now arises, what is growth? is it cancer? Most pathologists consider it as cancer, and Lebert describes some, though not all, of the nuclei, as having the characters of cancer-nuclei. The peculiar chemical composition of the mass, however, seems to claim for it a place by itself.

Its most frequent seat by far is the peritonæum and abdominal viscera, yet it is found in the female breast and elsewhere.

It has all the characteristics of cancer except that its progress is slow, and that it is slow in relapsing. It is an infiltrating growth, destroying the tissue it invades, spreading to adjacent parts, affecting the lymphatic glands, and appearing in remote organs; as in a case recorded by Lebert, in which a colloid tumour of the left breast of twelve years' duration destroyed the breast, appeared in the axillary glands, destroyed the intercostal muscles by infiltration; and invaded both lungs, the mediastinum and bronchial glands.

5. *Hæmatoid Cancer* (*Fungus hæmatoides*) is a variety of soft cancer, distinguished by its excessive vascularity, which is sometimes sufficient to cause a sensible throbbing like that of a vascular tumour.

* This cut represents the outward appearance of a colloid growth on the mesentery, from King's College Museum. See also Ballard, Med. Chir. Trans. vol. xxxi.; Sibley, *ib.* vol. xxxix., and a classical case in Lebert, Anatomie Physiologique, vol. i.

Hence arise extravasations of blood into its substance, giving it the appearance of blood-clot mixed with brain. If ulcerated, there are frequent hæmorrhages from the surfaces. This, however, is common to every form of rapid ulcer, cancerous or not.

6. *Cystic Cancer.*—Cysts may be produced in cancerous growths by the extravasation of blood, and the absorption of the coagulum, leaving in its place a clear or coffee-coloured serum. Or cancer may be superadded to a previously-existing cystic growth, and may grow from the walls of the cyst as a portion of hypertrophied gland may. Or, lastly (as in the case of cancer of the ovary), it may, from the first, assume the cystic form which characterises the morbid growths of that organ.

7. *Osteoid Cancer* (*Malignant osseous tumour*) is characterised, not merely by the partial ossification of the fibrous or periosteal tissue, intersecting a cancer when developed in or upon bone (which is common), but by the conversion of the newly-developed cancer stroma, first into fibrous tissue of extreme density, then into a peculiar bone. This bone when macerated and dried is exceedingly dense and compact, like ivory; yet dull in colour, rough and porous on its surface, extremely brittle and capable of being reduced to a chalky powder; and may be seen, under the microscope, to be imperfectly constituted as to its bone structures, and to contain an admixture of amorphous earthy matter. In the recent state its surface is covered and its interstices filled with the dense fibrous matter, and with a few cancer cells.

8. *Villous Cancer.*—This name has been assigned to a growth composed of the most delicate papillæ, containing each a vascular loop, growing from the surface of mucous membrane, and associated with cancer, or more probably with epithelioma. The bladder and gums are the usual seat of this growth.

CAUSES.—Under this head we have chiefly to confess our ignorance. Neither temperament, mode of life, civilisation, previous disease, nor moral causes have been proved to have any special predisposing influence. Domestic animals and cattle are quite as subject to the disease as man is. The dark and bilious are not more subject to cancer than the light and florid. The rich are rather more liable than the poor; but it is because they are not so often cut off beforehand by other diseases. The healthy and well-fed, the happy and prosperous, are as liable as their less fortunate brethren. The disease is alleged, however, to be more rare in tropical than in temperate climates; and, although there is no such incompatibility as is sometimes supposed between cancer and phthisis (because cancerous patients often display the signs of pre-existing tubercular disease, and many become affected with phthisis), yet it happens most rarely that any person actually phthisical is attacked by cancer.* External violence cannot be a cause of cancer, although it may perhaps occasion or hasten its development in the injured spot. In fact, the only known predisposing causes are,—

1. *Descent* from a cancerous parent, which seems to have some slight influence, and was found by Lebert to exist in about $\frac{1}{7}$ of a certain

* See case by Mr. Sibley, of concurrent development of cancer and pulmonary tubercle; and two other cases in J. Z. Lawrence on Surgical Cancer, 1855, p. 30.

number of cases. 2. *Sex:* for cancer is at least from ½ to ½ ... prevalent in the female. 3. *Age:* because nearly half of the ... number of cases occur between 40 and 60. Lastly—although ... is not contagious in the ordinary sense of the term, there seems ... for believing that, if fresh cancer cells are introduced into the ... they may be deposited and propagate themselves. The experiment ... been tried on dogs by Langenbeck and by Lebert; and cancerous tumours were found in various parts, when the animals were ... some time afterwards; yet it must be remembered that some of the tumours found in these cases may have existed before the inoculation.

General Pathology.—The ancients considered *scirrhus* to be ... consequence of inflammation, acute or chronic;—or to be a consequence of black bile. During the Hunterian era, it was supposed to depend on a peculiar action of vessels. Then it was believed that the cancer cell was something quite *heterologous*, alien to the human body, ... specific;—now the opinion of pathologists is veering round to the ... opinion—that cancer belongs to the same class of changes, as tubercle, chronic inflammation, &c.; and that it arises as they do, by unhealthy proliferation of existing cell or germinal elements. We know nothing of its essential nature. We say that it is the consequence of some ... known condition, to which is assigned the name of the *cancerous diathesis*. The type, and the most frequent variety, is the *encephaloid*, for although most of the cancers of the female breast are of the scirrhous variety, and although this is common in the periosteum, dura mater, and pylorus, yet in every other tissue and organ the encephaloid largely prevails. Cancer may occur at any age; Lebert has seen it in the brain of a child of seven months; and believes it may be developed in the fœtus in utero. Cancer of the eye is most frequent under 15; that of the female breast and of the uterus (which form more than a fourth of the entire cases of cancer) between 40 and 60; of the testicle between 20 and 50; of the intestinal tube in advanced life; while cancer of the bones is equally frequent at all ages.

The Progress of Cancer may be divided into three stages:—

1. In the first, it begins insidiously, gradually increases, and may remain for a time unnoticed, if in an organ (such as the skin or bone) whose functions are not active. In this stage the constitutional symptoms may be slight, if any.

2. The second is a stage of *active local progress*. The tumour grows faster; begins to adhere to and to infiltrate neighbouring tissues and the nearest lymphatics. And now, not only the functions of the organ affected, and of the others implicated by contiguity, become more decidedly deranged, but other symptoms manifest themselves peculiar to the morbid growth. *Pain* of a most severe, intermitting, neuralgic sort; gradually increasing in severity; felt in the tumour itself as a sharp, stabbing, or burning sensation; in the muscles and bones as a wearing rheumatic pain, often disturbing the sleep at night; sometimes preceding all local disease; sometimes not felt till it is far advanced, is one of the most marked symptoms of cancer. This is quite independent of other pain arising from pressure, distension, or stag...

So valuable a sign is *pain*, that if after extirpation of a ...ncer, the patient complains of neuralgia, secondary cancer ...st certainly predicted. This practical rule was communi... writer by his friend and preceptor Dr. Robert Ferguson. ... also, may occur several changes in the nutrition of the ...rth. A portion of the cells may undergo disintegration ...lar mass; preceded by fatty infiltration and formation of ...lar corpuscles; or by a drying up and condensation; and ... thus altered form a yellow tubercular-looking mass, ...h the rest of the tumour, which Müller described under the ...r cancer, and Lebert as the *phymatoid*. Ecchymosis, in... and abscess may occur, or ulceration; but be it observed ...on is by no means so common a phenomenon in cancer as ... taught, unless it be in hard cancer of the skin, breast, or ...fter ulceration, or before it, portions of the tumour may ...ay slough away; but none of these changes are curative; ...ne part is perishing, others are germinating and spreading ... Yet in a few instances, in aged persons, cancer has disap... ...trophy, and the breast with it.* In some few cases the ...al; but the cancerous mass beneath remains. The consti... ...ptoms of this stage are those of an increasing cachexia, ... detrimental consequences of pain, discharge, and interrup... ...tion. The complexion becomes sallow, the lips pale, the ...dent (though delirium in any case of cancer is rare), diges... ... the flesh and strength waste; and the bones become light

...rd period, *diffused* and *secondary* cancerous growths are ...e liver, uterus, bones, pleura, and other parts; and the in... ...ctional disturbance, added to the increasing decay of the ...es of the blood, ultimately prove fatal.

...us.—The final destiny of a cancerous patient is pretty ... time in which the disease may prove fatal is uncertain; ... in the soft than in the hard cancer; in young patients than ...d; and in cancer of internal organs, especially if of vital ... than of external. Some patients succumb in a few months; ...ve, if carefully treated, several years; two years, or three, ...sidered as more than the usual limits.

...ENT.—We know of no radical measures, capable of remov... ...rous taint from the blood, and of arresting the growth of ...ease. All that we can do is to check the disease so far as ... make the patient's life as long and as comfortable as our ...ill.

... thing to be spoken of is *extirpation; against* which must ...he facts—that the removal of one affected part cannot re... ...athesis, and that the disease is almost sure to return in the ...ation, or in some other. That in some instances outward ...ompanied by the disease inwardly, and that to remove the

* Case by Ernest Hart, Path. Trans. xiii. p. 225.

former would be taking away only part of the disease already eri
for instance, in cancer of the eye, or of the testis, some part with
head or abdomen is commonly affected likewise, and operations i
cases are most rarely successful. That some patients are killed
operation itself; and that some have died from being operated
what afterwards proved to be no cancer at all.

On the other hand, *in favour of extirpation*, it must be said th
may undoubtedly often be prolonged by it. That if the disease
return, an operation, thanks to chloroform, may be painless, an
interval one of health and comfort; and that it is possible the
may not be cancer, but some other growth which excision might

The first point the surgeon should consider is, whether an ope
can be performed without danger to life; for it would be both
and unjustifiable to perform it, if the health were so completely b
down, or visceral disease so advanced, that the patient was lik
sink after it, or if the diseased mass were so adherent, or exte
that it could not be removed effectually, so that the wound ma
the operation would not heal.

The methods of extirpation are two—the knife, and caustics.
knife is undoubtedly to be preferred in all cases as the most me
and decidedly so, if the tumour is circumscribed, and can be re
entire, leaving a wound capable of healing by the first intention,
to give the patient the chance of the most rapid recovery possible

Caustics, or astringent substances used assiduously, and in suf
strength to shrivel up and kill the diseased tissue, are of the gr
service in cases for which the knife is not available. In the ca
instance, of an open fœtid sore, or of a protruding mass giving is
blood or to fœtid sanious discharge, the chloride of zinc, in the fo
Burnett's solution, is an admirable thing. The writer has long
in the habit of using it in cancer of the womb; and its pow
checking fœtid discharge and bleeding, of allaying burning pain,
causing soft masses to shrink, are great. It may be applied in v
strength according to circumstances; so dilute as to be a
astringent and deodorizer, or so concentrated as to be a powerful c
The point seems to be to deaden the surface, then to get it to abs
much of the chloride as possible, so as to *tan* a considerable dept
to continue the process till the whole of a diseased mass comes o
slough.

One part of the solution to 64 of water is a good proportion to
with, but it may be increased. F. 117.

There are other caustics in great variety from which the s
may make his choice,* such as Manec's arsenical paste, or Canq
chloride of zinc paste, described at p. 81. Dr. Simpson recom
the sulphate of zinc dried and powdered, and sprinkled on the s
made into a paste with glycerine or lard, in the proportion of an
of the sulphate to a drachm of glycerine, or two drachms of lard

* An interesting account of them all is given by Mr. Spencer Well
Times, July 11, 1857. See also Simpson, Med. Times, Jan. 17, 1857.

liquescent, and like the chloride does not attack sound surfaces. ncentrated sulphuric or nitric acid, made into a paste with tow, , sawdust, or asbestos, is an efficient though less manageable ; the concentrated solution of chloride of iron, the acid nitrate rcury, the permanganate of potass, bromine, and various other s may be mentioned, but the sulphate or chloride of zinc appears st.

it be desired to penetrate deeply into a large mass of cancerous , it may be done in three ways,—by deadening the surface with de of zinc, and then cutting through the slough nearly down to ving part, and inserting more of the caustic into the incisions— puncturing and injecting a few drops of solution of chloride of as is done for nævus—or by inserting into the diseased mass small es or *stylets* composed of chloride of zinc, flour and water, baked ey are hard enough.*

the case of cancerous masses which are so adherent and extensive hey cannot be removed by the knife, and in which the skin is not cerated, we believe that puncture and the injection, or insertion escribed, so as, if possible, to eradicate the tumour with as little ction of skin as possible, is the best plan, if any plan of extirpa- e determined on.

ring the last ten years, a plan of treating cancer has risen, ished, and decayed in London, by which the public were promised. erely that local deposits should be removed, but that the disease d be eradicated from the blood. The means employed were, de- ion of the skin by nitric acid, and of the cancer by chloride of introduced into incisions made in the first slough. The chloride ixed with a red root—the sanguinaria—which has some stimula- roperties, but, so far as cancer is concerned, is inert. What the e and results of this treatment were, so far as the writer has had pportunity of learning, may be gathered from the following me- dum of one case :—

May 15th, 1857, he saw a lady, æt. 46, wife of a clergyman ; ess ; fifteen years ago she struck the left breast ; a *lump* ensued, y increased, and became of late very painful ; a gland in the axilla lso enlarged and painful ; she suffered severe pain in the tumours, bove the clavicle in the neck ; she had been seen by several sur- during the last five years, all of whom said that the case was t for an operation. In March, 1857, she put herself under the f a gentleman who professed to cure cancer. On the 25th, a large n of the skin of the bosom (including the nipple), and over the were destroyed by nitric acid ; after this, the slough was gently rough, and various substances inserted into the cuts ; the pain most agonising, and brought on violent flooding ; she sat in bed, after hour, rocking herself in agony ; the discharge was very pro- but an essential part of the treatment was that she was not

ol. Times, Feb. 7, 1857, p. 144. Maisonneuve, Clinique Chirurgicale. 1862, p. xliv.

allowed to keep her bed, but was taken daily into the open air in an easy chair: she lived well, and drank plenty of wine. In December the writer saw her again; she said that the first slough had been six weeks in separating, and that it was obliged to be removed by scissors; that the wound was six months in healing, if healed it could be said to be; for it had left a large tense red thin cicatrix adherent to the ribs, which cracked and bled every time she coughed. Her breathing was difficult, her cough severe, there were swellings above the clavicle, and evidently cancerous deposit in the chest. She was greatly emaciated; strength and appetite gone; pain constant. At the first interview she was hopeful, and said she had been relieved of the neuralgic pains above the clavicle; at this second interview she condemned the whole treatment as a delusion. She assured the writer that three ladies who had begun the treatment in March, when she did, were already dead; and she followed them in February, 1858. So this poor creature had passed the last year of her life in unutterable torture.

So much for extirpation. But the very hopelessness of the disease ought to stimulate the surgeon to use every effort to delay its course and soothe the patient's sufferings. The *growth of the tumour may in some cases be checked* by the incessant application of cold, by means of bladders filled with ice, or with a freezing mixture, on Dr. James Arnott's plan—or by pressure, with Dr. N. Arnott's slack air cushion. *Powerful astringents*, as the tannic and gallic acids, may delay the growth of, and check oozing from a rapidly-growing soft cancer. F. 186.

2. *Antiphlogistic* measures are quite powerless against cancer; but when it is mixed with some degree of common inflammatory effusion, which is apt to give a great impetus to the cancerous growth, a few leeches, cold applications, and alterative doses of Plummer's pill may be of great service.

3. *Tonics*, and especially the iodide and other preparations of iron, and quinine, are desirable in order to assist in forming healthy blood, and enabling the system to withstand the ravages of the disease.

4. *Specific* remedies—such as iodine and its preparations, bromine, arsenic, and ergot of rye—are not known to be of service.

5. *Narcotics* may be given most unreservedly, for the purpose of subduing the gnawing pain and irritation which tend rapidly to exhaust the nervous system. Opium in the solid form, given regularly and boldly, is the sheet-anchor. Conium and other remedies of its class may be tried.

6. As *local applications*, during the earlier stages, fine cotton wool dusted with iodide of lead, and an occasional painting with tincture of aconite, or application of a bladder of ice, or of a lukewarm lead and opium lotion, to relieve the neuralgic pain.

For the ulcerated stage the local remedies may be arranged under the following heads:—1. The soothing, including the opiate and conium lotions, F. 120, on lint covered with oiled silk; poultices, F. 157, medicated with the same remedies; chalk, lead, and bismuth ointments. 2. The gently stimulating; as the black-wash, carrot poultice, yeast

poultice, weak zinc or nitrate of silver lotions. 3. The astringent; as the lotions of iron and tannin, F. 128, 131; or poultice of bread and powdered matico. 4. The antiseptic; as lotions of the chloride of lime or of zinc, or of creosote, or iodine; of acetate or nitrate of lead, or Condy's disinfecting fluid. We may add that poultices should not be applied too warm; and that care should be taken not to let the skin around become pimpled or excoriated. If it should, the tannin lotion, or bismuth ointment, are the best applications. A flat bag of peat charcoal, dry, and wrapped in flannel, may be laid over the wound, to absorb effluvia.

7. The general health and strength must be carefully looked to, since whatever disorders these will hasten the progress of the disease. Good diet, cod-liver oil, change of air, tranquillity of mind, and means for securing a proper action of the eliminative organs, will greatly aid in prolonging life, and in lessening the sufferings which our art cannot prevent.

SECTION X.—ELEPHANTIASIS ARABUM.

Under the term Elephantiasis, two dissimilar diseases have been confounded: one, the Elephantiasis, so vividly described by Aretæus, the *Elephantiasis Græcorum*, which begins by tubercular swellings of the face; the other, the *Elephantiasis Arabum*, which we propose to describe here. It consists in a slow hypertrophy of the skin, areolar tissue, and bones, and in their infiltration with a peculiar cacoplastic deposit. The epidermis is thickened and the papillæ enlarged, *but not much*: the true skin is immensely thickened: its fibrous structure dense and almost rigid: the areolar tissue thickened, its areolæ expanded, and filled with oily or gelatinous-looking stuff. In cases which the writer has examined, the microscopical appearances were those of hypertrophy of the tissues involved. The bones also of the affected limb became enlarged and heavy.

This is peculiarly a disease of warm climates. The dark races are more liable to it than the fair. In India, it is particularly liable to attack the scrotum, which it converts into a huge tumour. (See *Scrotal Tumour*.) In the West Indies the leg is its favourite seat, hence the term *Barbadoes leg*.

The best description of it is that given by Mr. Dalton, an able practitioner of Guiana;* and from this it plainly appears, that it is from the first a constitutional malady. It begins insidiously with feverish or aguish symptoms, pain in the leg about to be attacked, firm doughy swelling resembling that of *phlegmasia alba dolens*, and some tenderness of the lymphatic glands. In the course of months, or perhaps of years, the patient suffers a frequent repetition of these attacks; the limb becomes permanently swelled, and in confirmed cases presents a huge, misshapen, useless mass, like the leg of an elephant; hard, and

* Lancet, 1848, vol. ii. p. 453. Mr. F. Day also describes the disease as consecutive to *malarious fever*. This is important. Path. Trans. xiii. p. 304.

that the surgeon has to deal with. If cancer, there will cancer cells, or if not, an abundance of cancer nuclei, and of cutaneous cancer, melanotic infiltration. On the con-*helioma* there will be found the epithelial cell, in every ged in adherent laminæ, with their large, flattened, and walls, containing, usually, a single nucleus not varying in the different cells, and there are the concentric loculated , or nests of epithelium. But as Lebert well observes, sible that *some* epithelial cells may be found so like *some* hat it is hardly possible to distinguish between them. In ever, it is the character of the great mass, and not of ssibly exceptional, specimens that should be regarded. ithelial tumours yield no *juice*; or if a liquid be squeezed ed up, it does not mix uniformly with water, as pus uice do, but runs into clotty or leafy masses, composed of rs of adherent and similar cells, with clear water in the the masses.

rtimes stated that cancer may be diagnosed by the *micro-earances of the discharge.* But this is fallacious. The ould perish on an ulcerating surface, and could scarcely hed amidst the pus and ichor present. Ulcerated epithe-e more easily distinguished, because epithelium is less de-d more likely to come off in coherent masses. The cut at sents a papilla from epithelioma of the bladder, found in d diagnosed during the patient's life.

ncer of the *fungus hæmatodes* variety, when abundantly l pulsating, may be mistaken for an *erectile tumour*, or *anastomosis.* But the long, perhaps, congenital duration e tumour, with the fact that the pulsating cancer must be l growth, and that the erectile tumour can generally be

fluctuating protrusions, and the non-occurrence of any implication of the neighbouring glands.

7. Enlargement of the *lymphatic glands* may be distinguished from cancer by the circumstance, that if one only is affected, it presents a smooth, uniform, or lobulated surface; that it is not adherent; and that it is neither so hard as the hard, nor so soft as the soft cancer. If several glands are enlarged, they are not adherent to each other, nor connected by hard bands of indurated lymphatics; they do not increase at the same rate as the cancer does, nor affect the general health.

8. *Tuberculosis* differs from cancer in affecting by preference the lungs and lymphatic ganglia in young subjects; whereas the eye and bones in the young, and the breast, womb, and stomach, in the old, are the favourite seats of cancer. Tubercular deposit may continue for an indefinite time, and may be perfectly eliminated by suppuration, or may undergo earthy transformation; and the general health may improve in time: not so with cancer. The small cells of tubercle, destitute of nuclei and nucleoli, mixed with solid amorphous matter, and floating free in a special juice like those of cancer, and not readily and equally diffusible through water, ought not to be confounded with cancer cells.

9. *Fibrous Tumours* present a rounded, smooth, firm, elastic surface, non-adherent, and not softer at some parts than at others; the neighbouring lymphatic glands are unaffected, and they may acquire large dimensions without serious cachexia. After extirpation, the naked eye will recognise the white fibrous tissue, with few vessels, and no infiltrating juice containing cancer cells.

10. *Enchondroma* differs from cancer in the circumscribed nature of the tumours, which leave the articulations and other neighbouring parts intact; in their smooth rounded surface; and in their not producing cachexia, even though multiple and of long duration. Microscopic analysis shows cartilage-cells embedded in a hyaline substance. But supposing that some of these cells are set free by the softening down of the intercellular substance, in which case they may have some resemblance to cancer cells, or even that a portion of enchondroma is contained in a cancerous growth, a little attention will prevent error.

11. Lastly, the *Fibro-plastic Tumour* seems more nearly allied to cancer in development and clinical history than any other except epithelioma, and often closely resembles it in rapidity of growth. Yet it usually differs from it in having its surface regularly and uniformly lobulated, and of uniform consistence; it is usually circumscribed and non-adherent, unless it has been subject to inflammation; it does not usually infiltrate other textures, nor affect the general health. In its microscopic elements, whether, as Lebert observes, it be of the soft gelatinous or of the red fleshy variety, there is an entire absence of cancer cells, and the constant existence of fibro-plastic cells, depicted at p. 24, and every series of forms between mere nuclei, and fibres elongated and fusiform. Yet it must be remembered that these tumours are exceedingly apt to return after extirpation; that possibly they

Spilla new vessels, may be squeezed out; this may persist
eloped condition, and form a *fibro-plastic tumour*; or may
d; or may degenerate into a scrofulous abscess, in which
d fibro-plastic cells appear as curdy flakes, or as one form of
terculous matter.

PART III.

DIFFERENT KINDS OF INJURIES.

CHAPTER I.

BRUISES AND SUBCUTANEOUS INJURIES.

SECTION I.—INTRODUCTION.

DEFINITION.—Injuries attended with the division of various t
without wound of the skin; or if with a wound of the skin, on
is very slight and quickly healed.

This definition includes *bruises* or *contusions*, that is, injur
flicted by blows with blunt weapons, as well as *strains* or
which consist in the rupture of tendinous or ligamentous fi
over-stretching; besides *simple fractures* and dislocations, an
subcutaneous wounds which are made by surgeons in tenoto
other operations.

Pathology.—There is a great distinction between injuries
and with wound of skin; for, as Hunter said, wounds, "in wh
parts do not communicate externally seldom inflame, while
the second order commonly both inflame and suppurate."

The general progress of subcutaneous injuries is this. At fi
is a certain amount of pain, consisting in a perpetuation of the
sensation of injury. There is some amount of extravasation f
blood-vessels which are torn: and there will be probably in
four hours some amount of throbbing or *inflammatory* pain,
increase of swelling, from inflammatory exudation. But if
does well, all inflammation soon ceases; inflammatory exudat
effused blood are absorbed; and there is a growth of pure
material, which fills the gap of the severed muscle tendon or
the case may be, and which infiltrates slightly the adjoining po
tissue. This soon begins to organise itself, after the manner d
in the Chapter on Repair, and becomes a fibrous tissue, by wh
severed parts are united.

If the blood be in a diseased state, and charged with mat

nmatory exudation, or if the reparative material be injured or rbed, a subcutaneous injury may lead to abscess.

e reason why a subcutaneous injury should be so much less erous than one in which the skin is divided—why, for example, a le fracture or dislocation should be comparatively safe, whilst a ound fracture or dislocation is a highly dangerous accident, appears this; that the wound in the skin may be easily hindered from ng by a variety of disturbing causes; and that the exudation, in ct with the air and external bodies, is liable to undergo decomposi- ; and that the state of decomposition may spread throughout the l, and give rise to various local and constitutional disturbances, ing from slight inflammation, or suppuration, to pyæmia.

reatment.—The general indications are, to put the injured part an easy posture and keep it at perfect rest; to apply moderate ure, so as to check exudation; to soothe pain, sustain the secretions strength of the patient, and so prevent inflammation and insure y repair.

SECTION II.—BRUISES AND ECCHYMOSIS.

EFINITION.—A bruise or contusion signifies an injury inflicted by blunt object, without perforation of the skin.

uises may be divided into three degrees. 1. Those which produce laceration of small vessels in the areolar tissue, and perhaps division of muscular fibre, accompanied by a limited effusion of into the part.

A *large vessel* may be ruptured, so that blood is effused in con- able quantity, and tears up the cellular tissue, in which it coagu- ; or if an artery is ruptured, a false or diffused aneurism may be esult.

The tissues may be irretrievably pulpified and *disorganised*; as ens from the contact of a spent cannon-ball, for instance.

ECHYMOSIS is an effusion of blood in the areolar meshes or sub- e of tissues. When ecchymosis has been produced in the skin or diately beneath it, there appears a swelling of a reddish colour, t speedily becomes black. On the third day it is violet, and the n, which was at first well defined, is found to be faint and diffused. t the fifth or sixth day the colour becomes green; on the seventh ghth, yellow; and it gradually disappears about the tenth or th—sooner or later, according to the vigour of the individual, and uantity of blood effused.

an ecchymosis be formed in the cellular tissue without injury of tis, no discolouration may appear for twenty-four hours; and if it re deeply seated among the muscles it will not affect the skin for days, and may then appear at a part quite remote from the seat ury; and, in this last case, will usually be in the form of irregular v spots, marbled with green and blue.*

* Devergie, Médecine Légale, Paris, 1836, tome ii. p. 57.

CAUSES.—Ecchymosis may be produced by many oth
besides contusions. It is a symptom of certain diseases, a
purpura, and the last stage of fevers. It may be a conse
oblique wounds, which do not permit the blood to flow freel
spasms, and other violent contractions of the muscles; it ma
caused by suction (as after leech-bites), especially in a part w
skin is thin. It may further be simulated by the appli
colouring matters to the skin. Lastly, ecchymosis produce
life may require to be distinguished from various appearanc
after death.

DIAGNOSIS.—*Ecchymosis produced by suction* may be dist
from that which is the result of injury, by being generally in
of small round spots, and situated on the inside of the arms
breasts; and the surgeon required to decide on the cause of su
should consider whether they correspond in their appearance t
which is assigned to them.

Artificial discolouration of the skin may be distinguished fr
mosis by its being generally in round or irregular spots, fring
edges.*

Ecchymosis produced during life may be distinguished from
discolouration of *incipient putrefaction*, or that which is cause
gravitation of blood in a dead body, by noticing that, in the
blood is effused into the cellular tissue, and is incorporated
cutis, which is thickened; whereas in the two latter cases, the
will be confined to the surface of the cutis, and if blood is eff
the cellular tissue, it will be only at some depending part, and
fluid, and not coagulated.†

TREATMENT.—The indications are (1) to check extrava
blood; (2) to prevent inflammation; (3) and afterwards to
absorption of the effused fluids and restore the use of the parts.

The bruised part should, if possible, be placed in a raised
and cold or iced water, or a bladder containing ice, F. 114, s
applied at once. These measures, together with rest, moderat
tives, and not too full a diet, will suffice for the first two ind
whilst the third will be fulfilled by friction with stimulating li
and a bandage after tenderness has subsided. For slight bruis
face, such as a black eye, the application by a brush or piece o
the surface of brandy or spirits of wine, or of the tincture of
or a solution of alum or tannin, will often prevent the effusion
or its extension by astringing the vessels.

If the effusion of blood is great—if the skin is so tense tha
inevitably either burst or slough—an incision *may* be made
swelling, but it is better avoided. Then the clot will be grad
truded by the contraction of the cavity, and a simple granulatin
will be left. But it is very bad practice to squeeze out the co

* Fallot, de la Simulation et de la Dissimulation des Maladies,
1836, p. 67.

† Beck's Medical Jurisprudence.

bleeding might be brought on afresh, and severe inflammation be

artery of considerable size is lacerated, which will be known by ation of the contusion, and the great and rapid swelling, the case treated as a *diffused aneurism*.

rs and toes, however severely bruised, should not be cut off.

CHAPTER II.

WOUNDS.

NITION.—Wounds are commonly defined to be *solutions of conti-* separations by external violence of parts normally united, or ous;—usually proceeding from the surface of the body or mucous

.

SSIFICATION.—The *incised* wounds, or those made with clean-cutting ents; the *punctured*, or those made by instruments whose greatly exceeds their breadth; including stabs, and pricks of all the *lacerated*, in which parts are torn; and the *contused*, or cted by bruising, are the chief varieties.

ncised are usually produced with the least violence, and generally most easily of repair. The *punctured* are dangerous from their and from the possibility that deep blood-vessels or viscera may ured, or that deep-seated extravasation of blood or abscess, may . The *lacerated and contused* wounds are commonly produced greater violence, less likely to heal, and more prone to slough or rate. They do not however, in general, bleed so much as incised ctured wounds, because arteries, when torn, contract more than ut. We must remember, however, that we may have a *clean* as well as a *clean cut*; the definition of a *clean* wound being that olence is expended solely in dividing parts, leaving the tissues er side uninjured. See the *Ecraseur*.

ATMENT.—The treatment of all wounds comprises four indica-—1, to check bleeding; 2, to remove foreign bodies; 3, to bring ided parts into their natural position and keep them in union; promote adhesion.

To check *bleeding*, moderate pressure, a raised position, and the ation of cold, will be sufficient in most cases; but if the bleeding obstinate, the measures must be adopted which will be pointed in the Chapters on Wounds of Arteries and of Veins.

The *removal of foreign bodies*, if any are in the wound, should effected as soon as possible, by the fingers or by forceps, or sponge

* Hunter on the Blood, part ii. chap. ii. sect. i.

and water. Dirt, gravel, &c., are best got rid of by affusion with lukewarm water. All clots of blood must likewise be removed.

(3) In order to *bring the sides of the wound into contact*, the part must be placed in such a position as will relax any muscular fibres that have been divided, or that lie under the divided parts. Then the edges must be made to meet as nicely as possible. On this point the surgeon should use the utmost diligence, because the more that the parts are adapted, the less chance will there be of suppuration, and the more speedy and free from deformity will the cure be. The edges of the wound may then be kept in their place by cross strips of adhesive plaster, one end of the plaster being first applied to that side of the wound which is loosest, and the other being brought across. Then a compress and bandage may be applied to keep on the dressings, and protect the parts from injury. It should be put on with such a degree of firmness as may feel comfortable to the patient and have the effect of preventing bleeding or other exudation. This point requires particular attention in subcutaneous surgery. If the wound is so situated that the plaster cannot be applied smoothly, a compress of lint may be laid on it first.

Collodion.—A very useful substitute for adhesive plaster in many cases is the solution of gun cotton in ether, commonly known by the name *collodion*. This when applied to any surface dries instantly, forming a semi-transparent film of considerable tenacity, adhering firmly, and forming an artificial scab under which wounds often heal without any suppuration. In applying it, the edges of the wound should be held together as exactly as possible by an assistant, whilst a thick layer of the collodion is smeared across with a brush or small spatula. It is useful to apply it in the intervals of stitches or plasters, in order to exclude the air. This substance contracts so strongly that

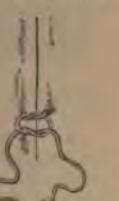
* 1. Fine glovers' needle; 2. Old harelip pin; 3. Curved surgical needle; 4. Fine steel needle for twisted suture.

should be put on in *one layer*, once for all; not in repeated layers, lest those which are put on afterwards will drag off those applied first. Thick mucilage sometimes is used for the same purpose; so is Friar's balsam.

Sutures.—In all extensive wounds, and most especially in wounds of the eyebrows, eyelids, ears, and other parts which it is most important to make to unite neatly, and in which plasters would be insufficient, *sutures*, or, in plain English, stitches, should be employed. Yet, unless for special reasons, the surgeon should not employ them in order forcibly to drag the lips of a gaping wound into contact, or they will give great pain, and his intentions will be frustrated by their speedily lacerating. They may be removed in from three to six days, or sooner if violent irritation comes on.

Five species of suture are enumerated in the old authors.

1. The *Interrupted Suture* is thus made. A needle armed with a single ligature is passed through the skin on one side of the wound *from without*, inwards; then at a corresponding part through the upper lip *from within*, outwards. Then the ends of the ligature (which may be made of silk, or hempen thread, well waxed) are to be drawn together, without, however, any great straining, and are to be tied tightly in a double-reef knot. Silver, iron, or leaden wire is sometimes used for sutures, and has this advantage, that it does not absorb fluids, and so cannot be converted into a seton; but it is apt to cut or tear when pulled out.



As many of these stitches are to be made as are necessary; half or three-quarters of an inch is a proper interval.

2. The *Twisted Suture* is made thus:—The edges of the wound are to be placed accurately in contact, and a sufficient number of pins is be passed through both of them at convenient distances. The first pin should be placed at any loose angle which there may happen to be. When all the pins have been introduced, and the parts are accurately adjusted, the middle of a long piece of silk is to be twisted around the uppermost in the form of a figure of 8. Then the two ends are to be brought down and twisted round each of the other pins successively in like manner; and, lastly, are to be secured by a knot.

The pins were formerly made of silver, with steel points which were removed after they were inserted, Fig. 2 (p. 34); but fine steel needles with lancet points, Fig. 4 (p. 34), are now used instead. After they are inserted their points must be cut off with pliers.

3. The *Glovers'*, or *Continuous Suture*, is nothing more than the

ordinary way of sewing things together practised by seamstr
housewives. It is employed in wounds of the intestines and st

4. The *Quill Suture* is performed by passing a sufficient n
ligatures with the needle here represen
instead of being tied to their opposite ne
all the threads on each side of the w
fastened to a bougie, or metallic rod, p
with holes. It is very advantageous in
the deep parts of a wound together, an
in lacerations of the female perinæum.

5. The *Dry Suture* was made by s
strip of adhesive plaster, or (before tha
vented) a strip of linen smeared with wh
and flour, to the skin on each side of the wound. The adjacen
of the plaster or linen were then sewed together.

(4) The fourth indication is to promote the process of adhesi
this purpose every circumstance that will disturb the lymp
or that will cause it to decompose, must be scrupulously avoid
wounded part should be kept absolutely at rest, and if the v
at all severe the patient should be sent to bed. Pain and m
turbance should be allayed, and sleep procured by opium ; th
ance of which in preventing fever and pyæmia cannot be over-
The bowels should be relieved, in order to combat any te
inflammatory exudation, and the diet be regulated. In most
as much light food as will replace the waste of a man at re
cient : in some it may be necessary to give meat and wine, i
make up for loss of blood, and supply material for healthy
No bandages should be tight enough to cause irritation or co
If much pain and swelling supervene, all tight applications a
must be removed, and fomentations or poultices be applied, till t
mation has subsided, or till suppuration is established. Then
may be again gently approximated, that they may heal by the
tention; that is, by the inosculation of their granulations. In
in other inflammatory cases, cloths dipped into cold water, or
filled with ice, is sometimes more comfortable than warm ap

Cases of complete Disunion.—If any small portion of
(a finger or part of the nose, for instance) has been complete
and if it be reapplied as soon as possible, and retained by
sutures, and wrapped up so as to preserve its temperature, i
probably unite again. And even if such a part have been se
a considerable time, the attempt should not be given up ; bu
be well washed with warm water to free it from dirt, and

bathed, so as to remove any dry coagulated blood, before plied to each other. One case is related in which the last e middle finger was cut off, and after an hour and a half and united firmly.*

OPEN WOUNDS.—If a part has been abstracted which tured, or if any kind of wound cannot be covered by skin, with lacerated and irregular wounds, the first plan on which ated, is by endeavouring to form a *scab*, by covering the pledgets of soft lint soaked in blood, which are to be ry and adhere. This is the natural and simple way in slight accidents heal when not interfered with by art; and has seen the large surface exposed by the removal of a st heal completely under a crust of blood in thirty days. ised remedy, the *Friar's Balsam*, or *Tinct. Benzoes comp.*, nt application for wounds attended with some degree of It causes the blood to coagulate, and seals up the wound tact of the air, and from infectious miasmata.

s no pain or bad smell, the wound should be allowed to ered till the scabs drop off, and show a cicatrix underneath. omes painful, and a fetid matter oozes out, warm poultices sing should be applied, and the wound be treated like a nulating sore.

d of attempting to form a scab, the surgeon may apply ng or poultices from the first, when, if the case proceeds the wound will become filled with a pink lymph, which low wounds forms a pliant cicatrix, without granulation, suppuration.

fter Wounds.—After punctured wounds, or after any ex- ical operation, or other wound, it is possible that part of on, or that some portion of coagulum may decompose and ration, even after the wound in the skin has healed; and nious fluid which results may find its way into the veins erious consequences. Pain and tenderness, restlessness and till cause the surgeon to examine the track of the wound nd to make an incision if there is any mischief underneath.

ED WOUNDS.—The first point usually mooted in discussing ent of these wounds is the propriety of dilating them, and them into simple incisions, in order to avert deep-seated and confinement of matter. But as those evils by no w of necessity, an endeavour should be made first to prevent this end, the part should be kept at perfect rest, and should d with an agreeable degree of firmness, so as to prevent s oozing of blood, which is the most likely cause of inflam- f necessary, low diet, purgatives, and cold lotions must ed. But if, notwithstanding, there should be severe pain, g, and fever, the case must be treated in the same manner ated abscess.

y, H. W., of Thetford, Et. Med. and Surg. Journ., July 1815.

CHAPTER III.

GUN-SHOT WOUNDS.

SECTION I.—GENERAL DESCRIPTION.

DEFINITION.—Under the term *gun-shot wounds* are included all the injuries caused by shot and other substances discharged from fire-arms, by fragments of stone or splinters of wood struck thereby, and by the bursting of fire-arms, and of shells.

"The CANNON-SHOT," says Mr. Cole, "for the first five or six hundred yards grinds to powder and destroys everything that opposes its hissing course."* If it strikes a limb it either carries it away or completely smashes it, pulpifying all the tissues with which it comes into contact. The shock in such cases is always very severe, and often fatal of itself. The hæmorrhage is usually slight: a gush of blood escapes at the moment the injury is inflicted, but the torn vessels soon retract, and the bleeding for a time is stopped. There were, however, a few instances, during the Crimean campaign, in which fatal hæmorrhage from the femoral artery was caused by cannon-shot injuries.

When the shot has travelled some distance, so as to have lost a portion of its impetus, the injury which it inflicts is often even greater. Instead of going right through the part struck, it will allow itself to be guided, or its course to be changed, by objects which it may meet in its way, and will thus give rise to wider and more serious injuries.

This happened in the case of a private in the First Royals, who was working in the trenches before Sevastopol. He was in the act of shovelling up some earth, with his body bent, and his right hand, in which he held the handle of the shovel, low down in front of the space between his legs. In this position he was struck by a round shot. It shattered his arm, leaving it hanging only by the integuments, and passing between the thighs at their upper part, it tore away from each of them a large mass of the integuments and muscles, and laid bare the femoral artery on one side. It carried in front of it the penis, and scrotum, and anus, and, guided by the curve of the buttocks, it swept away a large portion of the glutæi of one side.

Cannon-shot when nearly spent may produce severe injury without breaking the skin. Bones may be broken, or the deep tissues so contused as to lead to severe sloughing and loss of the parts.

However near the end of its career a round shot may be, it still carries destruction with it; and many a soldier's foot has been knocked off, when put out to stop a shot, slowly ricochetting along like a cricket-ball.

* Cole, J. J., Military Surgery, or Experience of Field Practice in India during the years 1848 and 1849. Lond. 1852.

It is rare for round shot to lodge themselves, yet a case occurred in the Balaklava action in which a six-pound shot was found lodged in a man's ham, with comparatively little distortion of the limb.

Much has been said of the effects of the *windage* of balls, that is, of injuries supposed to be produced by balls going near without touching, and ascribed to a current of air accompanying the ball. But later experience has shown the fallacy of all the views once entertained on this subject. Men's clothes have been torn, and even their caps carried off their heads by round shot, without producing any injury worth mentioning.*

SHELLS.—If a shell strikes anything before its explosion, it produces effects similar to those of round shot. After it has burst, the wounds inflicted by its fragments are not so severe as those of cannon-shot, although they certainly rank next in the amount of damage they produce. The large, irregular masses of iron often cause the most fearful contusions and lacerations of the tissues, and comminution of the bones. The extent of mischief produced by them may be estimated by the fact that during the late war the bursting of one howitzer shell caused ten admissions into the hospital of the 18th regiment, and that of the men so admitted seven lost an arm or leg.

MUSKET SHOT.—The largest number of wounds in any engagement is from musket balls. Until the late war, the old round leaden ball, fired from a plain or rifled barrel, was the only one in common use. Now, however, its place has been supplied by the conical ball, in our own and most of the continental armies, including those of our late enemies the Russians. As our men were wounded by both kind of balls, there were ample means of testing their destructive capacities. The conical balls being projected with much greater rapidity, are capable of passing through one or two men, and lodging themselves in the body of a third. They did not appear to deviate from their course to the extent that the old balls sometimes did. What they struck they usually perforated, in some cases drilling through bones, in others producing severe comminuted fractures. They lodge much less frequently than the round ones, and are far more destructive as instruments of warfare. Again, the ball may, if the force is nearly expended, lodge in the cancellous tissue of a bone, and form for itself a kind of chamber, in which it may be easily moved, but from which it is with great difficulty extracted.

Sometimes a ball will strike a bone longitudinally, and channel a long groove without fracturing the bone.

GRAPE SHOT produce wounds like those from round shot, only, as they are much smaller, so the injuries they inflict are less severe.

* "A shot ricochetted with great force over one of the parapets, carrying away the cap from a seaman's head. The man was a little stunned, but no further mischief ensued. When his cap was picked up, it contained a handful of hair, which had been shaved from the scalp by the shot. This would have been a 'poser' for the old wind-contusionists." Account of the wounded in the recent bombardments of Sebastopol, by D. J. Duigan, Esq., Surgeon R.N., attached to the Naval Brigade.—*Med. Times and Gazette*, Sept. 8, 1855.

CANISTER SHOT likewise cause wounds similar, though not so severe as those from musket balls of the same size.

SMALL SHOT, discharged from a fowling-piece or pistol, produce different effects, according to the distance at which they strike. If the distance is great, they will in all probability be scattered, and fall singly; *peppering* the victim smartly, but not penetrating beyond the subcutaneous tissue, nor doing much harm unless one of them strike the eye. But if the distance is small, so that they strike *en masse*, their effects are far more destructive than those of a bullet, for they spread *in* the flesh, and so cause greater laceration, besides the mischief arising from their lodgment in the tissues.

Although there may be no *ball* in a gun or pistol, yet the *wadding* may act as a ball, if the piece is discharged close to the body. The surgeon in civil practice who examines a gun-shot wound inflicted with intent to murder, should always save the wadding if he finds any, as it may afford a clue to the detection of the murderer. All gun-shot injuries, too, may be complicated with severe burns from the explosion of gunpowder.

Occasionally it happens that portions of the accoutrements, money from the pockets, or even pieces of bone from other soldiers' bodies are carried by the shot into the wound and lodged. A remarkable case of this kind is given by the late Mr. Guthrie, of two five-franc pieces being carried from the pocket of one man and lodged by a grape-shot in the thigh of the next.

In the naval action before Sevastopol a man in the cockpit of the "Albion" was dangerously wounded by a large piece of the jaw carried into his body from the head of a fellow-patient, while being dressed by the surgeon, Mr. Pritchard.

COURSE OF BALLS.—In the passage of the ball everything is as a rule carried in front of it, and we meet with fragments of the patients' clothing or pieces of wadding in the wound. Yet it is remarkable how easily globular balls may sometimes be diverted from their course by the slightest obstacle. An officer in the engineers returning one evening from the trenches before Sevastopol, was struck in the abdomen by a musket ball. It first impinged against a button of his trousers, which it bent double. This served to change its direction, and instead of passing into the cavity of the abdomen, it travelled downwards between the abdominal muscles, and lodged deeply in the upper part of the thigh. Any trifling obliquity of surface, or difference of density in the parts which it traverses, may cause it to take a most circuitous route.

Thus a ball may enter on one side of the head, chest, or abdomen, and may pass out at a point exactly opposite, just as if it had gone entirely through the cavity. In such instances the ball has generally been guided by a ridge of bone; thus, in the chest it travels round the ribs, or in the abdomen around the crest of the ileum. Sometimes it will make a complete circuit, as in the case of a friend of Dr. Hennen, who was struck about the *pomum Adami* by a bullet, which passed completely round the neck, and was found lying in the very orifice at

which it entered. In a similar manner balls will run along concave surfaces: thus a soldier may be struck in the wrist, when the arm is bent in the act of firing, and the ball may graze along the arm, and fly off at the shoulder: or a ball may enter the thorax or abdomen, glide along the inner surface of the peritoneum or pleura, and pass out or be lodged near the spine.

If a ball has passed through a part, an orifice of entrance and one of exit is usually found. *The orifice of entrance* is generally smaller than the ball, with its edge livid, and *inverted*. That of *exit* is a larger and more ragged opening, with its edge somewhat *everted*. The difference in appearance between the entrance and exit of the ball is, however, much modified by the speed at which the ball is travelling when it strikes the patient, and by the resistance of the parts perforated in its course through. The increased velocity with which the new rifles propel the balls, causes them to enter and leave a body without its offering sufficient resistance to produce a difference in the appearance of the two wounds. If, however, the speed of the ball's course be diminished, and a limb be then perforated by it, we have the characteristic appearances of its ingress and egress well marked.

The ball in its passage through a part leaves a track which is often indicated by a bluish or dusky-red line or wheal on the skin, or sometimes by a peculiar emphysematous crackling. Along this track the tissues are bruised and broken down, and their vitality greatly destroyed, and lying in different parts of it are the fragments of foreign bodies which the bullet may have carried before it.

SECTION II.—LODGMENT AND EXTRACTION OF BALLS.

Lodgment of Balls.—Wounds by gun-shot missiles may be either *penetrating*, usually attended by *lodgment* of the missile in some part of the body, or *perforating*, in which the missile passes through and out of the body or limb. It is always important to ascertain whether the shot has passed out of the body, or whether it has lodged; and supposing that there are two holes, it must be considered whether they are produced by the *entrance* and *exit of one*, or by the *entrance of two* distinct balls. If there are two holes, and they are distant from each other, some light may be thrown on the question by ascertaining the position of the patient at the time he was wounded, and the posture of his assailant. Thus, a soldier has presented himself with two shot-holes, one on the outside of the ankle, the other near the trochanter; but they were both caused by the same ball, which entered at the ankle when the foot was raised in the act of running.* In another instance, a soldier, who was ascending a scaling-ladder, was wounded in the right arm, and the ball was found under the skin of the opposite thigh.† As a rule, one opening only being present indicates that the ball has lodged, but, in some instances, it may have escaped by the hole at which it entered, after having made the circuit of the body. Or

* Guthrie, op. cit. p. 17. † Hennen, op. cit. p. 35.

it may have impinged against some part, such as the cartilage of a rib, which has caused it to recoil; and a ball has been known to drive a piece of bone into the brain, and fall out of the wound afterwards. In some instances a ball has been unable to perforate a fold of linen, but has carried it for the distance of one, or even three or four inches into the wound; and on drawing this out, the ball of course comes out with it.*

Again, it is very possible that two balls may enter by the same aperture, one of which may pass out, and the other diverge and wound some important organ. Sometimes it will happen that a ball splits either from a defect in the casting, or from its striking against some sharp bony ridge, as the vomer, or shin, or edge of a fractured bone of the skull; and although one portion may have been extracted, another may be lodged and may have injured important vessels or nerves.

But it frequently happens, that large masses of metal are imbedded in the substance of a part without much external sign of their presence, as in a case related at p. 139.

Detection of musket balls and other foreign bodies lodged in the wound.—A difficulty sometimes arises in determining the presence of a bullet in the wound. A hard body may be felt by the probe, but no clear evidence may be thus obtained as to whether it be exposed bone or a leaden ball. The famous case of Garibaldi was one of this kind, giving rise to great difference of opinion as to whether a ball was lodged or not in the cancellous substance of the tibia near the ankle-joint. In this case the French surgeon Nelaton, discovered the ball by means of a probe, the point of which carried a bit of unglazed porcelain. The absorbing nature and rough surface of this material enabled it to carry a portion of lead from the bullet when it had rubbed upon it for a short time. The nature of the stain was then proved by the ordinary chemical tests for lead.

On the same occasion, a magnetic probe was suggested by Dr. Miller of King's College, London, and constructed by the direction of Mr. Partridge. This probe, on coming in contact with metal at its point would cause a deflection of a magnetic needle connected with it. No other but metallic substances would have this effect upon the instrument.

For the purpose of detecting bullets a very simple, effective, and

practical instrument is used in the American army, the invention of Dr. Kress. Upon the end of a common steel probe is fastened a coil

* A silk handkerchief sometimes saves life in the same way; and Mr. Hall in his Report on Gun-shot Wounds in Canada, in 1838, speaks of the great power which the canvas lining of soldiers' stocks has in resisting the passage of musket-balls.—*Edinburgh Med. and Surg. Jour.*, July, 1840.

piece of hard iron or steel with a flat end, made rough in rectangular lines like a file. By placing the rough end of the cone upon the foreign body at the bottom of the wound and rotating the olive-shaped handle between the finger and thumb, particles of the metallic or other body can be rasped off, and retained in the grooves of the file-like end, and thus brought out for examination.

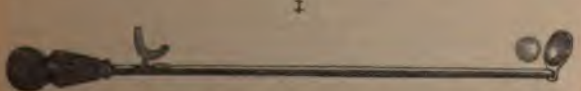
Extraction of balls and foreign bodies.—It is of the greatest importance for the future well-doing of the patient, that any ball or foreign particles which may have lodged should be removed by the surgeon. A most careful examination of the parts is always necessary. This should be made as soon after the injury as possible, before swelling and œdema of the tissues have come on. If the ball has traversed some distance, and it cannot be detected near the surface, a silver probe of about twelve inches in length is most useful, and will allow an exploration to be made along the track of the bullet. As a

rule, however, the best examination is made with the finger passed

†

into the wound, which may be enlarged if required. When the ball is

‡



deeply lodged, a bullet forceps will be found of great service. Excellent instruments are devised by Coxeter, Savigny, and others. When it is near the surface, a pair of straight incisor-tooth forceps will seize fast

* Forceps for extracting bullets.—*Weiss.*

† Pocket spoon and drill forceps for extracting bullets. It screws in the middle, and can be folded into a pocket case.—*Weiss.*

‡ Bullet extractor, with a cup, moving on a hinge by means of a slide.—*Weiss.* This probably would be cumbersome in use.

hold of a leaden ball and remove it with facility. If, however, the ball is lodged in bone, much difficulty is frequently experienced, and great tact required to get hold of it. A small channel may in some cases be made in the bone with a gouge, and the ball may generally then be removed with tolerable ease by means of one of Bell's sharp-pointed tooth elevators.

SECTION III.—COLLAPSE FROM GUN-SHOT WOUNDS.

COLLAPSE or SHOCK is the first constitutional effect of a gun-shot injury. It follows immediately or soon after the infliction of the wound, and is present to a greater or less extent in nearly every case. It is more intense in proportion to the severity of the injury, and according to the part of the body which has suffered; but even comparatively slight wounds are often followed by a very great amount of collapse. Gun-shot injuries of the thorax and abdomen are always followed by severe collapse.

The severity of wounds in these localities, when the cavity is opened, or the viscera wounded, is sufficient to account for this; but in instances where the ball has not penetrated the abdomen or thorax, but merely traversed their walls, there is still usually some shock, and often very much. The cause is probably partly the fear which men have of the result of wounds of either of the large cavities, believing that if a ball strikes the thorax or abdomen the case is necessarily fatal.

Another reason has been attributed for the collapse which is so universal, which is this. Men are generally wounded whilst under fire, while the nervous energies are in a state of extreme tension. They are suddenly struck down, and rendered *hors de combat*, and depression rapidly follows in proportion to the extent of the previous excitement, and thus we may meet with great collapse following even small injuries.

Mr. Matthew adduces, as proof of this doctrine, the fact that men were occasionally received for treatment in the Crimean hospitals before the excitement had subsided; and they seemed to bear the operations without chloroform well, and in some instances begged that it might not be given. The depressed condition may come on immediately after an injury, or, more rarely, it may not take place until some hours afterwards, a difference depending on the peculiar mental constitution and nervous development of the patient.

After severe gun-shot injuries patients may die from shock only. No large amount of blood may have been lost, or there may have been no destruction of parts which could cause rapid death, and yet the patient never rallies from the state of collapse, and speedily sinks. During the Russian war as many as 160 wounded men among the regiments of the line died within twenty-four hours, and 149 more within forty-eight hours after the infliction of their wounds, a very large majority of these deaths being due to this cause.

the stage of collapse, the patient presents a blanched surface pale, pinched, and anxious; the extremities cold; the l, weak, often irregular and fluttering; the voice feeble. usual condition of the patient, varying of course in degree, first seen by the surgeon. It is a question, therefore, ment whether it is best to rouse him from this state of

ure of the wound must answer this question. If the ball ated the thorax or abdomen, it is best not to attempt to rally on; vessels may be wounded which it is impossible for the secure, and this depressed state is most favourable for nature nagulum, and arrest hæmorrhage.

ient should be placed in bed, with his head low, and be watched, in order, by the judicious application of stimuth to the feet, &c., to prevent the collapse proceeding to an extent; in fact, to save him from sinking from the effects ich, if not carried too far, is most favourable for his ultivery. The same rules apply to all cases where large vessels , or are supposed to be wounded.

however, the injury is superficial, or even when it is deep ecting important vessels, the patient should be rallied from he has received as soon as possible, as reaction is generally tion to the amount of depression.

TION IV.—HÆMORRHAGE FROM GUN-SHOT WOUNDS.

RRHAGE.—*Primary or immediate* hæmorrhage following gunnds, especially if they are severe, is of comparatively rare

may be some slight bleeding at the time the wound is inut not, as a rule, in any dangerous quantity. During the war there were frequent instances in which the upper or remities were torn off by round shot or shell, and left merely by the integuments, and yet, in the majority of such immediate hæmorrhage resulted which at all jeopardized

un-shot injuries in which the blood-vessels are involved it is und that they are much lacerated, and retracted within ths, and thus hæmorrhage is checked for a time. Occasionally r where the femoral or some large vessel has been wounded, rrhage has rapidly proved fatal. In such instances, it is pro- the ball carried away a portion of the calibre of the artery, ntirely dividing it.

y elastic nature and yielding attachments of arteries and veins parts allow of an injury very near without opening the tube el. In one case given by Mr. Guthrie, a musket ball passed dy across the middle of the thigh and directly between the rtery and vein, bruising but slightly the coats of these vessels.

Both, however, became blocked up by coagula, and the pa
from gangrene of the limb.*

Intermediary hæmorrhage may occur some hours after t
of the wound, as soon as reaction begins, or after it has been t
established.

In such cases, if the application of pressure fails, the best
is if possible to cut down upon and secure both extremit
bleeding vessels.

Secondary hæmorrhage, or that which takes place at
period from the fifth to the twenty-fifth day after the inflict
injury, may be produced—

1st. By any sudden or violent movement of the patient, o
which increases the rapidity of his circulation. The coagula
temporarily closed the extremities of the wounded vessel,
away by the force of the blood, and bleeding immediately t
Thus patients during the Russian war frequently died of
hæmorrhage in being conveyed from the camp to Balaklava.
these cases and those of gun-shot fracture of the femur great
were derived from the easy means of transport by dhoolies
men, in the Indian campaigns. The *litières* and *cascalets* of
army, placed on each side of a mule, are also easier for th
than wheel ambulances.†

2nd. It may happen from sloughing, or ulceration of a l
The wounded tissues may ulcerate, or else may have been s
jured by the wound as to be incapable of recovering their vi

3rd. A vessel may be cut at almost any period after the
a projecting sharp spiculum of bone.

4th. A peculiar hæmorrhagic or scorbutic diathesis is
cause of secondary hæmorrhage, in an army reduced by
severe campaign.

This diathesis is often produced in long campaigns from
diet, such as a deficient supply of vegetable food, which ca
in the men, and renders them liable to hæmorrhage from
slight injuries. The blood thus wanting some necessary prin
incapable of forming coagula sufficiently firm to seal the mo
divided vessels;—or it may be poisoned by hospital air.

Treatment.—In all cases, if practicable, both ends of t
vessel should be tied; since, if either end is left open, the
may be carried on through collateral channels, and hæmo

* In the 44th regiment, on the night of the 21st June, 1855, a
left arm carried away at the shoulder-joint: the limb was complet
from the trunk, leaving too little of the soft tissues to cover in th
stump. The axillary artery appeared to have bled but little, if
moment of injury, and there was no subsequent hæmorrhage. T
laid bare the artery and vein for full three inches of their course.
the vessel for three quarters of an inch were curved, plugged with
tapering to a point. The pulsation of the artery was full to the
the plug.

† Williamson's Military Surgery, pp. 241—244.

e late Mr. Guthrie observes, in his Commentaries, that
not be done unless the vessel bleeds, "as hæmorrhage once
y not be renewed." A case occurred in the Crimea under
r which shows that even this rule will not always be the
patient's welfare, unless he can be kept under close obser-
ive from disturbance.*
e of the interosseous artery of the arm, owing to the diffi-
ing at the vessel situated beneath the deep flexors of the
geons have been induced to tie the brachial in preference to
ficult and tedious operation of securing both ends of the
Mr. Partridge in two separate cases tied the brachial at
ge Hospital for wounds of the interosseous, and in both
e hæmorrhage was entirely arrested, and the patients did
similar reasons, in wounds of the palmar arch, it is better
radial and ulnar; or should it be found that pressure on
o arrest the hæmorrhage, to proceed at once to tie the
her than explore beneath the palmar fascia for the cut ends
ing vessels.

V.—GUN-SHOT INJURIES ON THE HEAD AND FACE.

F INJURIES OF THE SKULL are the most unsatisfactory and
f cases which it falls to the lot of the military surgeon to
iagnose the extent of injury inflicted is often very difficult,
rrect appreciation of the nature of the wounds, and the
ated by them, is of paramount importance. Balls striking
ually cause fracture at the point they impinge against, and
of fracture of the base from *contre coup* are of rare occur-
itary practice.
sh wounds of the scalp may be produced by the grazing of
of a shell or musket ball. These injuries, if not severe, soon
der simple dressing and quiet. If, however, there is much
f the scalp, suppuration and burrowing of pus is apt to
death of a portion of the external table of the skull often

* was brought in on the evening of the battle of Inkermann who had
ough the leg at the junction of the middle and lower thirds. He
ge quantity of blood, and it was evident that the posterior tibial
een wounded, but it did not then bleed. The exhaustion was
e was placed in a tent, with a pledget of lint on the wound, the
and kept elevated, and an orderly left to watch him.
owing morning the pad of lint was removed, but no hæmorrhage
As the wounded had to be removed from camp to Balaklava, a dis-
o miles, and thence to Scutari by ship, it was thought best to tie
twithstanding it could not be made to bleed after all the bandages
from the limb. The operation was accordingly done, and it was
large portion of the calibre of the vessel had been shot away.
not this operation been performed, secondary hæmorrhage would
at some later period, and through the man's feeble condition have
tally.

Treatment.—Perfect rest, and the avoidance of all excitement. The bowels should be freely opened by purgatives, and the patient kept on low diet.

Fracture of the skull without depression.—Cases of this nature are of frequent occurrence, but are of far more serious importance than the foregoing class of injuries. They are usually accompanied with considerable contusion or laceration of the scalp. The symptoms which such an injury produces are uncertain: in some instances the patient is rendered insensible immediately by the blow, while in others he is apparently but little affected by it at the time of its infliction. The wound should be carefully examined *with the finger*, to ascertain if there is any depression. Often, when merely a fissure can be detected in the external plate of the skull, an extensive stellated fracture may exist in the inner table. This is usually referred to a greater brittleness of the inner table, but Mr. Erichsen has shown, by reference to the case of a man shot through the head from the mouth, that the external table may be more extensively fractured than the internal one, when the ball impinges on it from within. The chief reason seems to be that the ball in passing through the first table met with in its course has its velocity so much diminished that, in accordance with the usual law before referred to, the aperture of exit from the bone is larger than that of entrance into it. The external plate may, in some cases, be grooved by a ball, the parting to the touch the sensation of a depressed fracture.

The prognosis in all these cases is necessarily unfavourable, yet very many patients will recover perfectly. The external table may exfoliate and healthy granulations and perfect cicatrization may follow.

In unfavourable cases extensive suppuration beneath the scalp may come on, or the inner table of the skull may die, and abscess between the dura mater and bone, with its concomitant evils, may destroy the patient.

Treatment.—If the case is clearly one of simple fracture without depression, but little medicinal treatment is required. Cold applications should be kept to the head, and the bowels regularly opened if necessary, by purgatives. Perfect rest should be strictly enjoined, and all means of excitement avoided. If, however, abscess be diagnosed beneath the inner table, it should be evacuated by the removal of a portion of bone with the trephine. The period at which urgent symptoms set in after the injury will assist the surgeon in the formation of his opinion. The occurrence of severe rigors with head symptoms coming on from fifteen to thirty days after the injury, would give rise to a grave suspicion of the formation of pus.

Fracture of the skull with depression.—The symptoms of such injuries are so various, that it is impossible to lay down any correct law to guide the surgeon in his diagnosis. In some cases the indications of compression of the brain are strongly marked, while in others the patient, when first seen, appears but little affected.

If symptoms be urgent, and there be much difficulty in arriving at a satisfactory conclusion, whether there is depression or not, the wound

enlarged, so as to admit of a *visual* examination of the
art. In very many instances surgical skill can avail nothing,
rgeon has but to watch and soothe the dying man, and observe
e physiological phenomena presented.*
ent.—If the usual symptoms of compression are present, and
bone be *positively* detected, and there is a scalp wound, the
ay trephine. If, however, on the other hand, the bone is
essed, but no symptoms of compression be present, or if there
alp wound, the operation should be delayed until cerebral
have begun to manifest themselves.
ration of trephining is so fraught with danger, and experience
s that men will recover sometimes unexpectedly from the
e injuries, that unless there be *positive* indications for its use,
not be had resort to.
scalp be wounded and the skull comminuted, and the spicula
ng on the brain or its membranes, these should be imme-
moved, *without* waiting for symptoms.
sion of the brain from coagula of blood after injury to the
not unfrequent occurrence.
h cases trephining has been recommended; but the difficulty
ing correctly the seat of the coagulum, supposing hæmorrhage
have taken place, renders the operation very unsatisfactory, and
should be seldom resorted to. Moreover, it should be noticed
Stromeyer, who was surgeon-in-chief in the Schleswig-Holstein
against the Danes, in 1849, protests strongly against the use
phine, even in cases of depression, urging that the admission
ust exert a deleterious influence on a contused portion of
From the campaigns of 1849 and 1850 he possesses the notes
one gun-shot fractures of the skull with depression, and of these
en terminated fatally; thirty-four were cured, of whom one
been trephined.†
lodging in or penetrating the skull are almost always fatal.
as no instance during the Crimean war of a man recovering

brain of the 21st regiment in the Crimea, had the whole of the posterior
e skull depressed by a round shot, yet he lived two hours. A private
th regiment lived ten days after having, as it turned out at the post
a piece of the skull driven into one of the corpora striata.
he "Consolidated Statement of Gun-shot Wounds" rendered to Surgeon
Hammond, U.S.A., by Dr. John H. Brinton and referring to 20,930
ved during September, October, November, and December, 1862, an
s given of 35 cases of trephining performed in U.S.A. General Hospitals
mber 1862, to 31st March, 1863. Of these, 30 were from gun-shot
5 from other causes: 3 primary, 32 secondary: 5 recovered, 28 died, 2
d under treatment. Dr. Moses, Medical Director of the Army of the
ast, in the summer of 1863, in his "Surgical Notes on Gun-shot In-
Am. Journ. Med. Soc. April, 1864, says: "Gun-shot fractures of the arch of
e are almost universally fatal; and as far as my experience goes, it
ttle difference whether you trephine, remove depressed bone, or let them
All my operations for trephining have been unsuccessful thus far in the

from such injury. Many survived four or five days after se damage to the brain, but all these cases were eventually fatal.

GUN-SHOT INJURIES OF THE FACE are of frequent occurrenc present a greater amount of deformity than wounds in any other p of the body; nevertheless the issue of such cases, even when the bo are severely injured, is usually favourable, and a very large majorit the patients returned again to duty.

During the Crimean war, out of 535 men treated for these inju during the second part of the campaign, only fourteen died, or 2 per cent., and 83 per cent. returned to duty. Any part of the f may have the integuments lacerated, or perforated, or the bones s minuted, yet we have not any vital organ interfered with. The part vascular, and it is their vascularity which accounts for the rap with which repair is carried on. The chief danger is hæmorrhage, b still, as there are no very large arteries, the bleeding usually ce after a while.

If the lower jaw be torn away, the tendency of the tongue to f upon the glottis will be a source of inconvenience to the patient. the case of a private in the 31st regiment, who was wounded on 2nd September in the second attack on the Redan, the lower jaw w comminuted by a grape-shot, and the whole of it in front of t angles was removed in splinters by the surgeon. The tongue w apt to fall backwards on the glottis, and interfere with respira This defect the man used to remedy by drawing it forward w his finger, and by resting with his face as prone as possible. He ul timately recovered.

Two cases are recorded during the late war in which grape sh weighing nearly eighteen ounces had lodged in the back of the pharyn having entered through the face, and breaking down all the tissues w which they came in contact. One patient was a private in the 4 battalion of the Royals, and was treated in the Castle Hospital, Ba klava. The second was a private of the 31st Regiment.

Treatment.—Remove all loose spicula of bone, and adjust the pa as neatly as possible, covering them with some light water dress If the jaw be fractured, maintain it in position, either by the p forated wire or gutta-percha splint. The diet should be fluid, b good.

SECTION VI.—GUN-SHOT INJURIES OF THE CHEST.

GUN-SHOT WOUNDS OF THE CHEST may be divided into, 1st. Th in which the cavity of the thorax has *not* been opened.

2nd. Those in which the cavity has been opened; with or with injury to its contents. Of the second class, a very important practi distinction is that into *penetrating* and *perforating*. In the *penetra* wound the ball, besides entering the chest cavity, remains lodged e in its interior, or in some neighbouring part. In the *perforating* wo

has passed clearly out of the cavity by an aperture of *exit* in
to that of *entrance*.
e first class the danger is less than in the latter. Yet severe
n of the lung may result from a blow of a spent cannon-shot
horax; or life may be endangered from shell wounds causing
neration of the integument and injury to the ribs.
g wounds of the second class it most commonly happens that a
ses through the lung. Here we have a track through the sub-
f the lung, and generally pieces of the patient's dress, or frag-
f wadding, are found to have been carried before the bullet in
se; vessels must be torn through, and hæmorrhage, often to a
rent, will take place at some period after the receipt of the
This bleeding may occur in the following modes:—
om the vessels of the *chest wall*.
om the vessels of the *lung*.
former class (α) may be either, 1st, *external* through the wound
internal into the cavity of the pleura.
second class (β) may be *internal*: 1st. If slight, into the sub-
f the lung.
It may flow into one of the bronchi, and so be coughed up.
If more severe, it may be into the cavity of the pleura, com-
the lung, and adding much to the patient's sufferings and
; or it may be *external*. Possibly old adhesions of the lung to
m may exist, gluing the costal and pleural surfaces together,
other causes the blood may escape through the wound inflicted
missile.
Impaction of balls in the lung during the Russian war, owing to
of rifles, was more rare than in former campaigns. The danger
greater than when balls pass through the lung.
are, however, instances of men having lived for many years
ball in one lung. In such cases it becomes clothed with an adven-
yst, and thus coated, seems no longer to act as a foreign body.
ptoms of wound of the lung.—Great collapse; the face blanched
ious; difficulty of breathing in proportion to the extent of the
and probably some bloody frothy expectoration. In some cases
ded lung no blood is expectorated; while, on the other hand,
mere contusion of the surface of the lung by a round shot or
ball is attended by bloody sputa. Sometimes there is emphysema
region of the wound, but this is by no means a frequent or
y occurrence. Fractured rib is the most frequent cause of
ma.
gnosis in all penetrating wounds of the chest is unfavourable,
arly if the ball has lodged.
ment.—The patient should be placed in bed, and the wound
examined, to ascertain whether the ball has lodged, or passed
the thorax; and when no counter opening can be found, it will
detected lying beneath the scapula on the opposite side. The
should not be roused from the state of collapse, if it be not

into the pleura, *free venesection* should be had resort to, su
induce syncope and favour the formation of a clot. If
hæmorrhage is taking place there is no need of venesection, as
blood may be lost to produce the required effect. Much has
lately concerning the necessity or advisability of bleeding m
because they have received a chest wound. The late war in th
seems to point out that large bleeding for the arrest of the infl
action which follows gun-shot injuries of the chest, is injudici

Adhesive inflammation along the track of the bullet is de
is absolutely necessary for the purpose of limiting the infl
action to the wounded part. By largely bleeding the patien
ration is induced, and general, instead of local pneumonia is t

A low diet, perfect rest, anodynes, and diaphoretics seem to
patient the best chance of recovery, if he escape the first da
hæmorrhage. The position of the patient should be that
most comfortable, as that will probaby be the one which
favourable for his recovery. On the wounded side is generall
as that position favours the discharge of matter, approxi
opposed surfaces of the pleura, and quiets the movements o
on the affected side.

Treatment by hermetically sealing the wound.—In th
American civil war, a plan of treatment, proposed by Dr. H
penetrating wounds of the chest and abdomen is said to
followed by success. This surgeon considered that the custom
open the wound for the escape of blood is objectionable in
the continuance of the bleeding, increasing dyspnœa by
atmospheric pressure on the surface of the lung, and prom
putrid decomposition of the effused fluids. He first pares th
the wound, if made by a gunshot, thus removing the contu
unfavourable to union. He then brings together the edges
sutures, and puts on several layers of collodion, and then a
press and bandage, with the object of securing union by

by a decrease of mortality from wounded lung to the extent of 19 per cent. after one engagement.*

Complications and unfavourable symptoms.—Suppuration must always take place along the track of the bullet, and generally sloughing. It may be profuse, and the patient may sink under it. Severe pneumonia or pleurisy may add to the danger. A very frequent cause of death after these injuries is empyema, or the secretion of pus from the entire surface of the pleura.

SECTION VII.—GUN-SHOT INJURIES OF THE ABDOMEN.

GUN-SHOT WOUNDS OF THE ABDOMEN form a very fatal class of injuries. During the Crimean war 235 cases were treated, and of these 55·7 per cent. died.

They may be divided into—

1st. Flesh wounds of the walls of the abdomen.

2nd. Injury to the internal organs without lesion of the walls.

3rd. Penetrating wounds, with or without injury to the viscera or large vessels.

1st. *Flesh wounds of the walls of the abdomen* may be caused by fragments of shell, by which large portions of the integuments and muscles are often torn away, and portions of the intestines sometimes exposed. Bullets and bayonets will frequently traverse the abdominal walls without penetrating. No protracted examination should be made by the surgeon in such cases; but failing to detect the true nature of the wound, he should leave it for time to decide whether the cavity has been opened, or the viscera wounded.

2nd. *Injury to internal organs without lesion of the abdominal walls.*—Spent round shot or spent fragments of shell may strike the abdomen and inflict severe injury on the parts within, *without* wounding the walls of the abdomen. The liver, kidney, or spleen, or even the intestines, may be thus ruptured. The condition the abdominal muscles are in at the time the blow takes place will often determine the amount of injury. If they are perfectly relaxed at the time, the damage inflicted on the internal organs is usually severe, as no resistance is offered to the violence of the missile; whereas, if the abdominal muscles are rigid, they oppose or deflect the ball, and its impetus is expended in overcoming this opposition.

3rd. *Penetrating wounds of the abdomen with or without injury to the viscera or large vessels.*—The fatality which follows such injuries is very great. When the ball merely penetrates the wall and passes out of the abdomen *without* injuring its contents, the chief danger to the patient is from peritonitis. When, however, the viscera have been wounded the severity of the danger will, in a great measure, depend on whether it is one of the solid organs, as the liver, spleen, or kidney, which has been injured, or whether there has been perforation of the stomach or intestines. From the reports of cases, wounds of the liver,

* American Medical Times, Oct. 3, 1863.

of feces from the wound will indicate the nature of the injury
is often impossible to tell by a mere examination, and the
obliged to found his diagnosis on the symptoms present.
lapse is the first striking symptom ; if the viscera have been
it is very severe, indeed it is a common cause of death in
this region. When death does happen from shock, it is usu
that the intestines have been largely ruptured, or there
internal hæmorrhage. Frequent vomiting is a symptom
common in wounds of the intestine, particularly if the injur
high in the alimentary canal. There is usually pain in the
and frequently passage of blood by the stools. The after
are referrible, 1st, to peritonitis, and 2nd, to the organ w
have been wounded; *e. g.* the passage of blood by the urin
escape of urine from the wound, or of bile, or of any oth
secretion. If the intestine be wounded to a small extent, and
truding, the pressure of the adjacent viscera is usually su
prevent extravasation.

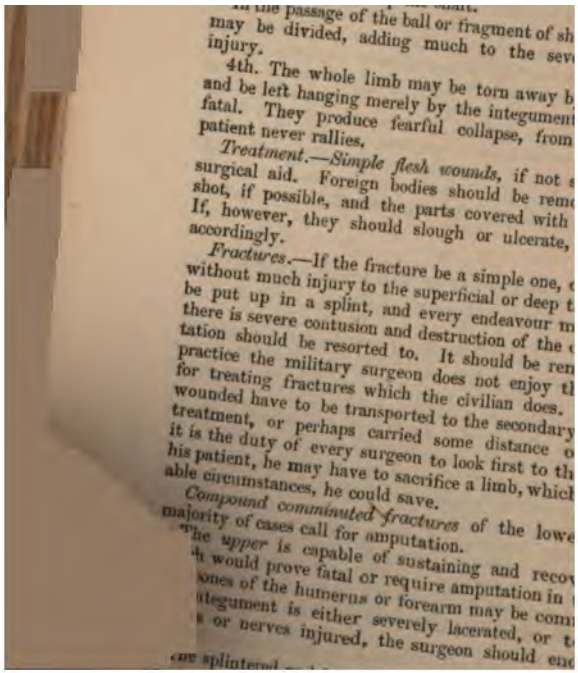
Treatment.—Having carefully examined the wound *with*
manipulation, place the patient in bed. He should not be hu
the state of collapse, unless it be so severe as to threaten a fa
nation. Should it be ascertained that the intestine is wound
search after the wound with the view of sewing up the open
the wound is only to the extent of two or three lines, the
through it of the mucous membrane is usually sufficient to
a while the flow of the contents until lymph seals up the op
larger than this a stitch is usually required. The protrudi
must be carefully cleansed and returned as soon as possi
suture used must be the *continuous* or *glover's* stitch,
only the peritoneal and cellular coats with the serous surfa
in, and opposed to each other, so as to adhere by effused lym
knot must be cut off short, and disposed of between the s
that the end shall fall into the interior of the gut when th

r that it does not follow that because a man is wounded in the
n therefore he must be bled. In injuries of this region adhesive
ation is earnestly desired. Prophylactic bleedings are believed
surgeons of the present day to be positively injurious; and it
ally considered that it is sufficient to meet actively an evil when
ts itself without submitting a patient to powerful remedies in
tion of a mischief which may never occur.
ually cases have been met with in which a ball after pene-
the abdomen has been lodged in the bladder. M. Baudens
l a ball from the bladder by the operation above the pubis, and
Mr. Guthrie succeeded in getting one away by the lateral opera-
Mr. Dixon* relates ten cases in which balls were successfully
from the bladder, and three in which the attempts failed.
re also on record of balls having been passed by the bowels
proving that they must have lodged in the intestine. Wounds
ver, though usually fatal from inflammation, are not necessarily
ases of protruding liver have been excised, and the patient
d.

VIII.—GUN-SHOT INJURIES OF THE LIMBS—AMPUTATION, PRIMARY AND SECONDARY.

SHOT WOUNDS OF THE EXTREMITIES are met with more fre-
than wounds in any other region of the body. Both the upper
er extremities are liable to similar wounds, but the danger is
ter in wounds of the latter. We may have—
Flesh Wounds, caused either by the passage or lodgment of
without producing any fracture of the bones, or injury to any
nt vessels or nerves; or they may be produced by fragments of
The injury inflicted by a bullet is not usually very severe, and
imple dressing may soon get well.
damage, however, which results from fragments of shell, often
severe sloughing and loss of parts, producing, if the patient sur-
e drain, great deformity from the contraction and cicatrization
issues which have been involved; for example, after wounds of
of the leg, in which there has been loss of a large portion of
cnemius.
Simple Fractures are usually caused by spent balls; and al-
, in such cases, the integument may not have been broken, still
g often follows from the contusion.
Fractures with destruction of a portion of the integument are
d—
) By balls penetrating the limb and striking the bone.
) By fragments of shell which may produce severe contusion
ration of the integuments and muscles, and fracture of the

* Med. Chir. Trans., vol. xxxiii.



in the passage of the ball or fragment of sh
may be divided, adding much to the sev
injury.

4th. The whole limb may be torn away b
and be left hanging merely by the integument
fatal. They produce fearful collapse, from
patient never rallies.

Treatment.—*Simple flesh wounds*, if not s
surgical aid. Foreign bodies should be rem
shot, if possible, and the parts covered with
If, however, they should slough or ulcerate,
accordingly.

Fractures.—If the fracture be a simple one,
without much injury to the superficial or deep t
be put up in a splint, and every endeavour m
there is severe contusion and destruction of the
tation should be resorted to. It should be ren
practice the military surgeon does not enjoy th
for treating fractures which the civilian does.
wounded have to be transported to the secondary
treatment, or perhaps carried some distance o
it is the duty of every surgeon to look first to th
his patient, he may have to sacrifice a limb, whic
able circumstances, he could save.

Compound comminuted fractures of the lowe
majority of cases call for amputation.

The *upper* is capable of sustaining and recov
h would prove fatal or require amputation in
ones of the humerus or forearm may be com
tegument is either severely lacerated, or t
s or nerves injured, the surgeon should en

are splintered

lower extremity the shock and effects of injuries on the constire more severe, and they are attended with great danger to l this danger increases the nearer the injury approaches the rounds of the upper third of the thigh being far more fatal se in the lower third. Amputation is frequently called for, hould be remembered that the danger of amputation of the xtremity is in an increasing ratio for every inch of the limb taken away. This applies especially to the thigh. Thus we the Crimean returns the following—

Amputations.		Total.	Died.	Ratio of Mortality per cent.
Thigh	Upper third .	38	31	86·8
	Middle third .	56	31	55·3
	Lower third .	46	23	50·0

total percentage of deaths in the Crimea after the amputation the *upper* and *lower* extremities was as follows:

Of the hip	(all died)	100	per cent.
,,	thigh	64	,,
,,	leg	37	,,
,,	foot	16	,,
,,	shoulder joint	35	,,
,,	arm	19	,,
,,	forearm	7	,,

said, however, that the statistics, from *all sources* that can be upon, allow that in amputation of the hip joint, one patient out te recovers. After the battle of Waterloo, Mr. Guthrie per- this operation upon a French prisoner under very unfavourable stances (nineteen days after) with a successful result.*

CASES REQUIRING AMPUTATION are,

Those in which the limb has been torn away by a round shot ll.

. Severe laceration of the integuments, with injury to the main , both artery and vein, even though the bone be uninjured. he artery only is wounded, both ends of it should be tied and an our made to save the limb; but if both vein, artery, and nerve been torn, the injury is generally so severe that it is best to ate.

. Severe compound and comminuted fractures, with destruction of rrounding tissues, even though the vessels and nerves be not l, demand amputation.

* Williamson's Military Surgery, p. 186.

Primary or Secondary amputation.—By the term *primary* is understood an operation performed within forty-eight hours after an injury, and before fever and inflammatory symptoms have set in.

Secondary amputation is that which is delayed until inflammatory symptoms have subsided and suppuration established.

The experience of modern surgeons has decided that amputation, when necessary, should be primary. The late Mr. Guthrie found the loss after secondary operations was at least three times as great as after primary. The experience of the surgeons in the Crimea corroborated this fact to a great extent. The result of the primary and secondary operations during the second period of the Russian war were in the following table, which is copied from the Crimean returns:

	Primary Operations.			Secondary Operations.		
	Total.	Died.	Ratio of Mortality per cent.	Total.	Died.	Ratio of Mortality per cent.
Amputations of all kinds	690	175	25·3	89	38	42·7

It is said that among the Russians in this war there were 3,000 amputations. Of the primary amputations of the arm, lower leg, and foot, one-half recovered; of the lower and middle thirds of the thigh, two-thirds died; of all the secondary amputations more than two-thirds died.

The patient should, if practicable, be allowed to recover from the state of collapse. Too early an operation is liable to be attended with even worse results than one at a much later period. If, however, there is hæmorrhage, or any cause which is likely to prolong the collapsed state of the patient, the operation should be performed as soon as possible.

GUN-SHOT WOUNDS OF JOINTS form a class of cases of peculiar interest, inasmuch as they often allow the principles of conservative surgery to be carried out in the treatment of them. Such injuries to the joints of the *lower* extremities are of more serious import than those of the upper. In the former the joints are larger and the danger to life seems to be in a great measure in proportion to their size.

Joints are sometimes severely injured, without any wound of the integuments covering them; thus in cases where the knee has been struck by a spent round shot, inflammation, perhaps terminating in suppuration, may follow.

Pieces of shell or bullets may lay open a joint, causing, at the same time, severe destruction of the soft tissues, and perhaps fracture of one or more of the bones which enter into the formation of it.

A ball has lodged in the extremity of one of the long bones

near a joint, a fissure will often extend into the joint. In the case of a man who was shot accidentally in the streets of Balaklava, by a soldier who was firing at a fierce bullock, the ball lodged in the upper part of the tibia. With some difficulty it was removed, but severe inflammation and suppuration of the joint followed, which terminated in the death of the patient. On the post-mortem examination it was found that a fissure extended into the joint. Occasionally bullets will pass through a joint, grooving, perhaps, the articular cartilage. Cases of this nature are most severe, and are more dangerous than those in which the joint has been more fully exposed, as in shell wounds.

Secondary implications of joints.—Joints are very frequently implicated, secondarily, from the inflammatory action set up by wounds in the neighbourhood extending to them, and involving them in its destructive effects. Private Waldron, 2nd battalion Rifle Brigade, received a bullet-wound over the left knee. The wound appeared superficial, and the joint not to be penetrated, but low chronic inflammation of it set in, and was followed by gelatinous degeneration. The limb was ultimately amputated, and the joint found quite disorganized.

In cases of pyæmia, secondary deposits of pus may take place in any of the joints. In such, free and early incisions seem to afford the best chance to the patient.

Treatment.—In injury of joints, especially of the large ones, and if the damage done be severe, the question of treatment becomes usually one of amputation or excision.

The experience of the present American war, by the almost unanimous testimony of their surgeons, is, that primary amputations in the thigh, and still more secondary, for gun-shot fractures have been very unsuccessful indeed, few escaping a fatal result; that resections of the comminuted bone or fractured joint have been a little less fatal: but that the most favourable results have ensued by treating the cases as ordinary compound fractures, after removing loose fragments, by suspending the limb in a Smith's or Hodgen's splint (see *Fractures*); by *free incisions* to let out matter; and by constant irrigation with cold water. Out of forty-six cases of wounded knee-joint, so treated in the Baltimore Hospital from June 1862 to October 1863, seven died, five remained under treatment, and sixteen transferred to other hospitals.*

Dr. Moses, Medical Director of the army of Cumberland in the campaign of 1863,† says that no rules derived from the English army of the Crimea, where the men were starved, can be applicable to men well fed and cared for, as the American army; that he saved eight out of thirteen cases of gun-shot fracture of the femur; and five out of ten cases of gun-shot wound of the knee-joint. Absolute rest; extraction of the ball and of loose splinters; irrigation with cold water; and *free incisions* for discharge of matter were the means.

* Peters, in American Medical Times, Oct. 3, 1863.
† Am. Jour. Med. Soc., April, 1864.

the humerus, only one died.

The best modes of performing the operatio
under the heading "Excision of Joints" in an
It may, however, be here mentioned, that, in
great aid will be given to the operator by us
forceps to seize hold of the articular extremi
proceeding to saw them. The great use of
plified in the following case. A private in
Crimea was struck by a round shot in the u
fearfully lacerating all the tissues and commi
as its neck. Amputation of the hip was perf
Trousdell and Mr. Lawson, the head of the
rated from the shaft, being with facility turne
aid of this forceps, a proceeding which would
sible without them.

In all operations for gun-shot injuries, chl
most useful adjunct. It not only deprives
during the search for balls and foreign bodie
tedious proceeding, but it serves to quell, to a
anxiety which is generally present. The patie
a sound sleep, free from injurious excitement, a
that what has been done for them will lead to

CHAPTER IV.

EFFECTS OF HEAT, BURNS, A

DIVISION.—The most useful division of bu
is the threefold one which has existed from
1st, burns producing *mere redness;* 2ndly,
3rdly, those causing *death of the part burned.*

is philosophically said to consist of perpetuation of the
use of burning.
the second class there is a higher degree of inflammation,
e cutis to exude serum and form vesicles. These in trivial
up and heal; but if the injury to the cutis has been sufficient
t to suppurate, they will be succeeded by obstinate ulcers.
third class of burns is attended with mortification from
ation of structure. These are, for obvious reasons, not
with so much pain as the last class; but in every other
hey are infinitely more serious, and the sores which remain
separation of the sloughs are often months or years in

ITUTIONAL SYMPTOMS.—The constitutional symptoms of
rns are those of great collapse. The surface is pale, the
s cold, the pulse quick and feeble;—there are violent and
shiverings, and the patient often complains most urgently
In some fatal cases these symptoms are soon succeeded by
breathing, coma, and death; in others, dissolution is pre-
a period of imperfect reaction, with delirium, and sharp
ulse.

SONS.—*Extensive* burns, even of small severity, are always
s; and especially if vesication has occurred early, and the
n been stripped off. *Burns on the trunk* are always more
s than those of an equal extent on the extremities. With re-
the symptoms actually present, it may be noticed, that although
e pain, such as is common in burns of the second class, is in
urce of great danger, from its tendency to exhaust the vital
still that it is on the whole a favourable symptom, if the in-
tensive; and that apathy and stupor indicate urgent peril.
periods of danger in burns are three: 1st, during the first five
m collapse or imperfect reaction; 2ndly, during the sympa-
ver which follows, in which the patient may sink with an
of the head, chest, or abdomen; thirdly, during the suppura-
, in which he may die from the profuse discharge or from pul-
consumption induced by it. Kentish observes that very many
ve fatal on the ninth day.

ID ANATOMY.—A *post-mortem* examination readily accounts
oma and laborious breathing, which are such constant symptoms
burns. Congestion and serous effusion are found on the surface
the ventricles of the brain; and the air-cells of the lungs are
ith a thin muco-serous fluid, as in the "*suffocative catarrh of*
" of Laennec. Moreover, it has been shown by Mr. Cur-
at severe burns in young people may be followed by an acute
n of the duodenum, liable to terminate fatally by perforating
tine and causing peritonitis, or by opening some large artery
ing effusion of blood, part of which may be evacuated by

. Chir. Trans. vol. xxv.; Humphrey, Association Journ., Oct. 19.

vomiting and purging. Mr. Murray Humphrey has observed ulceration of the lower part of the œsophagus. See page 34.

TREATMENT.—The treatment of burns in their early stage has been a matter of great dispute. Some eminent surgeons* have advocated ice or other cooling applications; others, the use of turpentine and other stimulants, which latter plan of treatment was advocated by Mr. Kentish, of Newcastle, at the beginning of the present century.

The following, however, seem to be the *principles* of treatment deducible from the conflicting theories and practices which have been proposed, viz.:—1st, that the first applications should be of a mildly-stimulating nature; 2ndly, that after the first two or three days they should be soothing; till, 3rdly, slight astringents may be applied to expedite the healing; and, 4thly, that the part should throughout be most carefully preserved from the atmospheric air and from cold. If these principles are held in view, the surgeon will have no difficulty in finding appropriate remedies.

Local Treatment of minor cases.—The vesications may, if tense, be pricked with a needle, and the whole part be covered with lint soaked in *Carron oil;* that is, a liniment of equal parts of oil and lime-water, and then be wrapped in soft cotton wool. After the first two days poppy lotion, or the water-dressing, F. 121, may be applied on lint covered with oil-silk; or a poultice of bread and water, till suppuration is established; the chalk ointment, or zinc lotion, may be applied afterwards till the cure is complete. The part should be kept thickly wrapped in cotton wool during the whole period, to preserve it from the air and from cold and injury.

Of severe cases.—When a burn is severe or extensive enough to cause danger to life, Kentish's plan of first bathing the burnt parts with tepid turpentine, then with all possible expedition applying a liniment composed of *ung. resinæ* ℥j.; *ol. terebinth* ℥ss., thickly spread on lint, and lastly, wrapping them up warmly in cotton or flannel, seems to be the most judicious. These dressings should be allowed to remain as long as possible, and should not be removed unless there is a profuse discharge or bad smell from the wound. Great care should be taken, when the wound is first examined, not to strip off the cuticle, whilst taking off the patient's clothes.

Constitutional Treatment.—If there is an urgent degree of collapse (see Part I., Chapter I.), brandy and beef-tea must be given.

If there be much pain it should be quelled by opium. Children are commonly said *not* to bear opium well, but this is a vulgar error; they bear it well if there is adequate reason. The writer has administered ♏x. of Battley's sedative, in divided doses every night for a fortnight to a child of three years old, who had been badly burned, besides putting her daily under chloroform while the wound was dressed. If the child is out of pain, or drowsy, of course there is no need for opium; and in all cases it should be given in the smallest doses that will suffice.

* Earle's Lectures on Burns, Lond. 1832.

The bowels must be kept open by castor-oil or rhubarb; and the diet be plain, but not too low. In the event of any inflammatory or congestive attack of the head or chest, purgatives and leeches or bleeding must be cautiously employed, according to circumstances. If there is any tenderness under the right hypochondrium, or vomiting, or other sign of irritation of the duodenum, the diet should be of the blandest description, and small doses of hyd. c. cretâ and henbane be administered.

Treatment of the remaining Ulcers.—The ulcers resulting from burns are often extremely intractable. The granulations are pale, flabby, and exuberant; they secrete pus profusely; and many months often elapse before they are healed. The cause of this disinclination to heal is not well understood; but one cause there is which may be easily detected and remedied, namely, too full a diet, which is often needlessly used on the plea of supporting the strength under the profuse discharge. "There can be no doubt," says Kentish, "that full diet and stimulants, during the suppurative stage, keep up irritation in the system, and cause the immense continued discharge by the exposed surfaces of the wound."* And it is equally certain that many cases will rapidly get well when the diet is lowered and purgatives are administered. The binding down of the edges of the ulcer to the condensed tissue beneath is another cause of delay.

There should be no hurry in removing the first dressings; but when they are removed, the succeeding applications must be suited to the state of it.

If the ulcer is irritable and painful, or hot and swelled, or seems inclined to spread by ulceration, or if small abscesses threaten to form under the skin, poultices, or water-dressing, or F. 121, Dover's powder at bed-time, and aperients should be resorted to. If sloughs are tardy in separating, the case must be treated like the sloughing ulcer. A very useful application in cases requiring gentle stimuli and complete occlusion of the air is a mixture of equal parts of balsam of Peru and olive oil, brushed smoothly over the surface with a soft brush every night and morning. It has the additional advantage of partly overcoming the fœtid smell.

When the irritable state is removed, a succession of mild stimulants and astringents will be advisable: especially the zinc lotion; chalk, bismuth, zinc, or calamine ointment; simple lint; and pressure with sheet lead or strips of plaster. When the discharge is very profuse, the sore should be constantly kept thinly covered with very finely-powdered chalk.

Treatment of the Cicatrix.—The cicatrix of severe burns is very liable to become excessively hard, dense, and cartilaginous, and to contract in such a way as to occasion the most serious deformities. Thus, the eyelids or mouth may be rendered incapable of closing; the chin may be fixed to the breast, or a limb be rigidly or immovably bent.

* Second Essay on Burns, Newcastle, 1800, p. 64.

This contraction may, perhaps, be sometimes successfully
keeping up extension with a splint, or, if the neck is the p
by making the patient wear a stiff collar, and by frequently
part during cicatrization; and the cicatrix may be lubricate
oil. If the fingers are severely burned, lint should be inte
tween them, and they should be kept apart as much a
although it will be very difficult to prevent them from adh
ther.* In burns of the head or face, the edges of the ulc
drawn asunder by strips of adhesive plaster. When any of
of the body are involved, they should be kept dilated with
plugs of oiled lint. But if, notwithstanding every preca
cicatrix contracts, and produces deformity, or prevents any
motion, the knife should be resorted to. Sometimes the wh
may be extirpated, the wound being treated by water-dressi
parts kept in a proper position during the cure. Sometimes
may be made in the sound skin on each side so as to form g
will be filled with new and more pliant cicatricial tissue.
it will be useful to divide the cicatrix transversely by severa
at the same time dissecting it up from the parts beneath it
adheres to them. Mr. Skey's plan is to make a multitude
transverse cuts through the cicatrix in the quincunx arr
which on healing increase the area of the total cicatrix. B
be remembered that operations which interfere with large p
skin are very dangerous to life; and that the subcutaneo
should be employed where practicable. And, lastly, there
which has been adopted with success by Dr. Mütter, an Am
geon, of dividing the cicatrix, dissecting it up, where adherent
dividing any muscular fibres in order to liberate the parts c
and then filling up the gap by means of a Taliacotian opera
is, by transplanting a portion of sound skin from some ne
part.† In a very aggravated case of contraction of the ci
severe burn of the whole surface of skin on the back of the w
and forearm, in a young girl, drawing the hand completely
forearm and rendering the limb totally useless, Mr. Wood
College Hospital, transplanted a flap of skin *from the sur
abdomen*, with such complete success as to restore entirely
the hand, with comparative small deformity. This comp
plantation from a remote part has not before been at
modern surgeons, apparently from the want of success in th
of the older surgeons to establish the similar operation of Ta
the restoration of a mutilated nose. In attempting such an
great attention and care are required in the selection and ad
the flap, and in the easy fitting of the apparatus for retainin
about to be united in perfect apposition.

* Vide Part IV. chapter xxiv.

† Vide Earle's Lectures on Burns, Lond. 1832; Dupuytren, Clini
Mütter on Deformities from Burns, in the American Journ. of M
1842. Several successful cases by Mr. Parker, of Bridgewater,
Ranking's Half-yearly Abstract, vol. iii. p. 106.

In the same case, a severe contraction of the skin of the neck, binding the chin down to the sternum, was successfully overcome by *adjacent* transplantation of skin, in such a manner as to produce a narrow longitudinal cicatrix, after removal of the more resisting portions of the original cicatrix producing the deformity.*

CHAPTER V.

THE EFFECTS OF COLD.

I. EFFECTS OF SEVERE COLD.—When a person is exposed to very severe cold, especially if it be accompanied with wind,—or if it be during the night,—or if he have been exhausted by hunger, watching, and fatigue—he feels almost an irresistible impulse to sleep, which, if yielded to, is soon succeeded by coma and death. During the state of coma, the body of the sufferer is found to be very pale and cold: the respiration and pulse almost imperceptible, and the pupils dilated; but the limbs are flexible as long as life remains, unless the degree of cold be very great indeed. On a post-mortem examination, the chief morbid appearances observed are great venous congestion and serous effusion in the head.

II. FROST-BITE.—But if the trunk of the body be well protected, the cold may affect some exposed part only, such as the nose, ears, or extremities. The first visible effect is, that the part becomes of a dull purplish-red colour; an effect of cold which is notoriously frequent, and which depends on a diminution of the quantity of blood conveyed by the arteries, and a stagnation of it in the veins. If the cold continue, the venous blood will be gradually expelled by a contraction of the tissues, and the part will become of a livid, tallowy paleness, perfectly insensible, and motionless, and much reduced in bulk. When in this condition, a part is said to be *frost-bitten*. The patient may be quite unconscious of the accident that has befallen him until he is told of it by some other person; especially if it be his nose or ear that is affected, or some other part that he does not move.

It was shown by Hunter that the ears of rabbits and combs of cocks may be frozen so as to be quite white and hard and brittle, and yet recover with proper care. And some of the lower orders of animals may be entirely frozen and yet survive. But it is not credible that a whole limb of a human being, much less that the whole body, could be frozen without death ensuing—although stories of such occurrences have long been current amongst authors.†

The indications are to promote reaction, but to avoid too sudden a transition from one extreme to the opposite.

* Medico-Chirurgical Transactions, vol. xlvi. p. 149.

† See an account of some experiments on the revival of toads after freezing in the Lond. and Ed. Journ. Med. Sc., Feb. 1843.

Of Frost-bite.—The best remedy for a frost-bite is to rub well with snow. After a time cold water may be substitute snow, and the friction may be rendered brisker. These ap must be made in a room without a fire; and a high or even rate temperature must be avoided for some time. By these other inconvenience will ensue, save slight swelling and tingl vesication and desquamation of the cuticle; although the par main weak and sensible to cold for some time.

For the *coma induced by cold* the best remedy is friction wi all over the surface of the body; the patient should be put to room of moderate temperature, ammonia and weak wine and administered, and, provided the breathing is restored, a warm be given.

The *contact of any intensely-cold body* (such as frozen causes severe burning pain, followed by vesication. It thu that the effects of sudden abstraction may be similar to tho great communication of heat. The best application is ice permitted to thaw.

III. GANGRENE may be caused if cold be applied contin the extremities, especially of ill-fed persons; hence the freq gangrene of the feet (*gelatio*) amongst the starved soldie Crimea. It may be caused, too, if heat be injudiciously applied or frost-bitten parts. It may also ensue if a part has been for a long period to a *low temperature* which is *suddenly* although the cold may not have been sufficient to cause actu bite, and may have been tolerated without inconvenience. example of this accident is related by Baron Larrey,* as it aff French troops during their campaign in Poland in 1807. Du few days preceding and following the battle of Eylau, the most intense, ranging from 10° to 15° below the zero of Re But although the troops were day and night exposed to this weather, and the soldiers of the Imperial Guard, in particul nearly motionless for more than twenty-four hours, there were plaints of its effects. On the night of the 9th of February, *a sudden thaw commenced*, and immediately a number of sold sented themselves at the "*ambulances*," complaining of sever ness, weight, and pricking pain in the feet. On examination, s found to have slight swelling and redness at the base of the dorsum of the foot; whilst the toes of others had already beco and dry. And in this manner, the toes, and sometimes the w perished. One case, exactly similar, was treated by Mr. Sol Thomas's Hospital in 1845. The patient, not very tempe been employed a whole day in January in handling raw cow-h the evening, feeling his left hand excessively cold and stiff, h into warm water, and held it to the fire, which excited great inflammation, ending in gangrene, which spread up to the

* Med. de Chir. Mil., tom. iii. p. 61.

† From 20 to 25 degrees below the freezing-point of Fahrenh

the fore-arm.* The best *treatment* for such cases is the application of snow or very cold water, followed by evaporating lotions. These, if employed early enough, may prevent gangrene; or even if that have actually occurred, they should be used as long as it appears to be spreading. Subsequently, the part should be wrapped up in resin ointment and cotton wool, and not be disturbed more than is necessary for cleanliness' sake; in most respects, the treatment of senile gangrene should be followed.

IV. CHILBLAINS consist in an atonic inflammation of the skin, induced in delicate persons by sudden alternations of temperature; such as warming the feet and hands by the fire when cold and damp. They may present themselves in three degrees. In the *first*, the skin is red in patches, and slightly swelled; with more or less itching or tingling, or perhaps pain and lameness. In the *second*, there are vesications—the skin around being bluish or purple. In the *third* degree there is ulceration or sloughing.

Treatment.—Friction, with stimulating liniments, such as F. 146; or liniment of turpentine, or of camphorated spirit, is the proper remedy. In most cases, port wine, bark, and cod-liver oil will be of great service.

If there are *vesications*, care must be taken not to break them; and the liniment must be applied lightly with a feather.

If there are *ulcers* or *sloughs*, and they are attended with much heat, pain, and irritation, poultices are required. But as a general rule, poultices are too relaxing; and stimulating ointments or lotions (such as *ung. resinæ, calaminæ, zinci*, &c.) should be preferred.

CHAPTER VI.

THE EFFECTS OF MINERAL AND VEGETABLE IRRITANTS.

Of these substances, some appear to act by their power of combining with, or of decomposing, the animal textures. Of others, especially the vegetable poisons, the reason of their hostility to animal life has yet to be discovered.

I. ACIDS.—This decomposing agency of the concentrated acids appears to depend mainly on their affinity for water. The *sulphuric acid* blackens or *chars* the tissues in destroying them; that is, separates the water and other constituent elements, and sets free the carbon. The *nitric* turns them permanently yellow. The *hydrochloric* leaves a dead white stain. The *hydrofluoric* "is, of all known substances," says Turner, "the most destructive. When a drop of the concentrated acid of the size of a pin's head comes in contact with the skin, instantaneous disorganization ensues, and deep ulceration of a malignant character is produced."† *Phosphorus* seems to act by the heat disengaged in its combustion.

* Quoted in South's Chelius, vol. i. p. 128.
† Elements of Chemistry, 5th edit. p. 377.

Treatment.—After injury from any of these acids, the first thing to be done is to wash it away, and neutralize it by repeated ablution with warm soap and water, with a little carbonate of soda; then to apply poultices or any simple dressings to the ulcers that remain. The pain of these injuries is greatly increased by cold.

II. Alkalies and Caustic Earths.—These, like the acids, appear to destroy animal matter by combining with its water. They also form a soap with the fat. Caustic potass, in the form of *liquor potassæ* and quicklime, are the substances of this class which most frequently give rise to accidents. The *liquor ammoniæ* produces almost instant vesication and great pain when it touches the skin; it is, therefore, much to be prized as a speedy and efficient counter-irritant.

Treatment.—Ablution with weak warm vinegar and water, followed by poultices and simple dressings.

III. Metallic Compounds.—The *bichloride of mercury* acts by its tendency to combine with albumen; and the *chloride of zinc* and *chloride* (or *butter*) *of antimony* probably produce their cauterant effects in a similar manner. The *nitrate of silver* is remarkable for the superficiality of its effects. It may vesicate the skin, or destroy a film on the surface of a sore, but its action does not spread. It suffers decomposition at the moment of its contact with the animal tissue; its acid appearing to be separated, whilst the metallic oxide combines and forms a white crust with the animal matter: and this soon becomes black, because the silver loses its oxygen, and is reduced to the metallic state.

Treatment.—The bichloride of mercury is rendered inert by white of egg mixed with water; the chloride of antimony is decomposed by water; the nitrate of silver by common salt; and the chloride of zinc by a solution of alkaline carbonate. These, therefore, would respectively be the proper applications for external injuries caused by these metallic compounds; although such cases very rarely come under the surgeon's cognizance.

Arsenic, locally applied, not only produces inflammation, or sphacelus, but may also be absorbed into the circulation, and produce its ordinary constitutional effects as well. The *surgical treatment* of any local injury from this mineral must consist in removing it as much as possible by ablution with lime-water, or with water holding the hydrated peroxide of iron in suspension, and then applying fomentations, or whatever other dressings may be most appropriate.

IV. Acrid Vegetables.—The inflammation excited by these substances requires merely soothing fomentations and emollient dressings. The smart from the sting of nettles may, it is said, be allayed by a weak infusion of tobacco, or the cut surface of a raw onion, if severe enough to require any remedy at all.

If an irritating fluid have been injected into the cellular tissue, free incisions must be made, both to allow its escape and to afford exit to pus. By this means sloughing of the skin may often be avoided, although very likely to occur when the subjacent tissue is extensively disorganised.

CHAPTER VII.

CTS OF THE POISON OF HEALTHY ANIMALS, AND TREATMENT OF POISONED WOUNDS GENERALLY.

TION 1.—EFFECTS OF POISONOUS INSECTS AND SERPENTS.

ECTS.—The bites or stings of any insects that are met with in nd are not of sufficient importance to need surgical assistance, inflicted in extraordinary numbers, or in peculiar situations. awrence* mentions the case of a French gentleman who was rely stung by bees about the upper part of the chest, that he n fifteen minutes, with all the symptoms of mortal collapse y produced by the bite of venomous serpents. Children, if much by bees or wasps, may suffer severely from headache and fever. he most common instance of danger from these insects is the ing suffocation produced when their sting is inflicted in the pha- or back part of the mouth, which sometimes happens when they ncealed in fruit, and are incautiously taken into the mouth.

eatment.—If a person have been stung sufficiently to cause faint- r constitutional depression, cordials and opiates must be admi- ed without delay. Respecting the *local treatment*, the first thing done is to examine the parts with a lens, and extract the stings a fine forceps, if they have been left in the wound, as they very ntly are. Then the best applications are the diluted liquor nia, spirit of hartshorn, or spirit of sal-volatile; carbonate of or chalk; vinegar, or eau de Cologne; also, soap liniment, or ound camphor liniment, may be used to remove the œdematous ng that remains. The author has been informed by a friend at y, that a poultice of ipecacuanha is there considered to be a e for almost every kind of venomous bite.

the case of a *wasp or bee-sting in the fauces*, with urgent danger ffocation, leeches may be applied externally; and gargles (espe- hot salt and water) should be frequently used, in the hope of re- the tumefaction, by causing a copious flow of blood and of saliva: these measures fail of affording relief, an opening must be made he larnyx or trachea.

the bites of bugs, fleas, gnats, mosquitoes, &c., the treatment is me.

SPIDERS.—The most celebrated of this class is the tarantula, the ulous effects imputed to the bite of which are too well known to epetition here; and we can feel but little hesitation in subscrib- the opinion of Ray, "that the dancing of the *Tarantati* to tunes and instruments, and that these fits continue to recur as long as the tarantula that bit them lives and then cease, other than acting fictions, and tricks to get money." We

* Lecture, Med. Gaz. vol. v. p. 582.

learn, however, from the least romancing of the old writers, that it produced swelling, lividity, and cramps, which were cured by scarifications and wine; and these are just the symptoms it might be expected to cause, and the most rational cure. The effects of the scorpion are similar. There is one very singular case on record, of a gentleman bitten on the penis by a spider, in America, suffering from violent vomiting, deep-seated abdominal pain, and suffocative spasms in consequence. He was relieved in thirty-six hours by bleeding, opium, and ammonia.*

III. SERPENTS.—The venom of these animals operates, as Fontana observed, by "destroying the irritability of the nerves, and disposing the humours to speedy corruption." The symptoms produced vary in their nature and degree, according to the species of serpent, its degree of vigour, the frequency with which it may have bitten, and the strength of the sufferer. Some serpents can kill only small animals: the poison of some is very virulent, but soon exhausted by frequent biting: that of others is mild but not easily exhausted; some, again, act so energetically on the nerves, as to cause death speedily by convulsions; others produce inflammation of the lungs; and others, whose venom is insufficient to annihilate the nervous functions at once, kill more slowly by the unhealthy or diffuse inflammation which they excite at the bitten part.

VIPER.—This is the only poisonous snake in the British Isles, but it is not often that it kills human beings. The properties of its venom were most painfully investigated, in every possible point of view, by the Abbé Fontana;† who ascertained that it is a yellow viscous liquid, not inflammable, and neither acid nor alkaline; that it contains no salts; and that it has no taste, except perhaps a slight astringent sensation if it is kept in the mouth for some time. It is not hurtful to another viper, nor does it appear to affect certain cold-blooded animals, as leeches and frogs. Moreover, it is perfectly harmless if applied to any natural mucous or cutaneous surface; so that large quantities of it have been swallowed with impunity.

COBRA DI CAPELLO.—Dr. Russell found that this was capable of killing a serpent called *Nooni Paragoodo*, but not another cobra; and that its poison was insipid when taken into the mouth, and productive of no ill consequences when applied to the eyes of chickens. The symptoms produced on animals bitten by it are fainting and convulsions, but no swelling; the lungs are stuffed with blood.‡ In the case of a keeper at the Zoological Gardens who was bitten on the root of the nose by a cobra, on the 20th October, 1852, there was no swelling, though there was a slightly-pinkish hue of the eyelids;

* Ray, Phil. Trans. 1698, vol. xxi. p. 47; Boccone, Museo di Fisica; Hunter, Am. Journ. Med. Sc., May, 1839; Gozzo, Gaz. Med. 1845, quoted in Ranking, vol. ii.

† Felix Fontana, Treatise on the Venom of the Viper, translated by Joseph Skinner, 2nd edit. Lond. 1795.

‡ Patrick Russell, M.D., F.R.S., An Account of Indian Serpents, 2 vols. folio, Lond. 1796. Davy, Physiological Researches, Lond. 1839.

dyspnœa, stupor, paralysis of the extremities, and coma came on, and the patient died in 95 minutes. Artificial respiration and galvanism were the remedies employed. The chief points of interest in the post-mortem examination were a dark, alkaline, and fluid state of the blood, which emitted a peculiarly sour and sickly smell; and intense congestion of the lungs, spleen, and other internal organs.* Mr. Buckland, in dissecting an animal which had been bitten by a cobra, became infected through a scratch on the finger, and felt great prostration, which he relieved by ammonia.†

RATTLESNAKE.—This snake, unlike most others, is capable of poisoning itself. Capt. Hall made one bite itself, and it died in eight minutes. Its effects, according to Sir E. Home, may be divided into two stages, either of which may prove fatal. During the *first*, which may last for sixty-two hours, the symptoms are those of great prostration of the nervous system, and contamination of the blood; vomiting, deadly coldness, faltering pulse, the skin livid or jaundiced, bleeding from the nose, fainting fits, convulsions, and delirium. Meanwhile the bitten part swells immensely from effusion of acrid serum, and becomes mottled with blood, extravasated under the skin; and this swelling extends to the trunk. Sometimes it is attended with excruciating pain, sometimes with mere numbness or coldness. During the *second stage*, large diffused abscesses form in the swelled parts, which contain bloody unhealthy pus and sloughs of cellular tissue, and are attended with low fever. After death the body putrefies very rapidly.‡

SECTION II.—TREATMENT OF POISONED WOUNDS.

In the first place, measures must be taken to remove the poison from the wound or to destroy it.

This may be attempted by passing a ligature tightly round the limb, as near as possible to the wound, and between it and the heart, or by cutting the poisoned part clean out: then by thoroughly sucking the wound and bathing in hot water, to encourage bleeding; or by putting an exhausted cupping-glass over it; or, lastly, by cauterizing it. This may be done by liq. ammoniæ, caustic potass, or nitric acid; or if the patient can be chloroformed, there need be no scruple in using a red-hot iron.

The *treatment of snake-bites* consists in the administration of powerful diffusive stimulants, such as hot brandy and water, whisky, ammonia, or the *eau de luce*, which should be given abundantly in as large quantities as the patient can swallow them. In America, what is called the *Western Cure* consists in making the patient drunk; and very large

* Lancet, Oct. 30, 1852.

† Buckland, F., Curiosities of Natural History, Lond. 1857.

‡ Sir Everard Home, Phil. Trans. vol. c. Case of T. Soper, who was bitten by a rattlesnake. Hall on the Poison of Rattlesnakes, Phil. Trans. vol. xxx. p. 398. Case of Mr. J. Briental, who was bitten by a rattlesnake, reported by himself, Phil. Trans. vol. xliv. p. 147. Case of a man bitten by a rattlesnake to cure lepra, Clarke, Lancet, Dec. 15, 1838.

quantities are required. Vomiting of bile seems to be a
symptom and effort at elimination, and may be treated by m
and by a mustard poultice to the epigastrium. If the patie
swallow, spirits and ammonia may be injected into the sto
rectum; and if the breathing flags, it must be kept up by
or artificial respiration.

Arsenic, in doses of a grain in solution every half-hour,
six doses, is a remedy which has proved successful;* but
ammonia are less hazardous.

Parts that are swelled should be well rubbed with linime
monia: if abscesses form, early incisions will be requisite.

SECTION III.—ENTOZOA AND PARASITES.

1. The GUINEA WORM.—*Dracunculus*, or *Filaria Medin*
cylindrical thread-like worm, but sometimes as thick as a
and several feet long. It is endemic in Africa, India, and
countries, whence persons often return to England with this
them. The worm appears, whilst exceedingly small, to pen
skin and effect a lodgment in the cellular tissue, where i
dormant for some time, and gradually increases in size till it
as a little tumour, or perhaps as a cord-like ridge under
feeling like a varicose vein. At last a very painful boil for
breaks, and allows the animal's head to protrude. Often, at
if injured, a considerable quantity of milky fluid exudes from
on examination, is found to be full of small filariæ. If
neglected, violent inflammation and abscesses ensue; to prev
the animal must be carefully extracted entire. If the head
protrude, a cut should be made across the track of the anim
should be gently lifted up, and then a small roll of plaster be
it, round which it should be carefully wound, day after day
extracted. Extreme cleanliness, and the application of assaf
said to act as preventives.†

II. The CHIGOE (*Pulex Penetrans*) is a minute insect, al
the West Indies, which penetrates the skin of the feet, and
little cyst beneath it, in which it deposits its eggs. When
fully formed, it may be of the size of a pea, and is of a blui
The symptoms are a violent itching. The treatment consists
ing the bag containing the creature and its eggs, which opera
terously enough performed by the negroes with the point
and the cavity left is filled with tobacco ashes. If the bag i
the extraction, so that the young chigoes escape, violent inf
is the result.

III. The ECHINOCOCCUS.—This is a minute gregarious a
habiting a cyst, filled with a watery fluid, which is commo
by the term *hydatid*. "The cyst of the echinococcus," says

* A letter to T. Chevalier, Esq., on the effects of arsenic in count
poison of serpents, Med. Chir. Trans. 1813, vol. ii. p. 396.

† See a paper by M. Maisonneuve in the Lancet for 1845, vol. i. p

ither singly or in numbers in the interior of a cavity, rganized false membrane, to which it has no kind of ad- r. It is found of all sizes, from that of a pin's head, to ches in diameter." When recent it is transparent and mersed in spirit, or in water, it becomes opaque; and osmosis in the former, distended from imbibition in the alls of the cyst are laminated, and of variable thick- ns a perfectly limpid liquid. On its inner surface may

rod irregularly, a number of granules, like grains of sand; ed by the innermost layer of are detached by the slightest cipient decomposition. Each les consists of a delicate mem- ing a mass of echinococci, all ort pedicles to a central stem matter, which also attaches inside of the hydatid cyst. occus consists of a rounded ably solid matter, containing ll bodies under its outer coat, ll surrounded with a circle of es, precisely resembling those and cysticerci. These teeth characteristic, and not easily decomposed.

ococcus cyst is most frequently found in the liver: it may, r in the bones, or in the areolar tissue; especially about deep amongst the muscles at the root of the neck. The ptoms are those of an encysted tumour, which, if punc- exit to a clear serous or purulent offensive fluid (for the containing the hydatids may suppurate); and the hydatid ves, or portions of them, will shortly protrude. The dia- btful cases will be determined by finding the teeth: of the le can be said beyond free incisions if superficial. If the sented a puncture with a small trocar and canula drawing and then injecting a solution of the iodide of potassium is tice. Some have used an injection of creosote and other ll the parasites, and check putrescence.†

TICERCUS CELLULOSÆ is an animal of the same descrip- receding, but larger, of the size of a pea. It has been found r chamber of the eye, the cellular tissue of the lids, the ngue, the areolar tissue and muscles. It should, when de- oved by incision.‡

rmost has its head protruded; the lower one shows the teeth in mal while living, and the neck a little protruding. 200 diameters. k in Trans. of Microscop. Society, vol. ii. p. 14; Dixon, Med. d. xxxv.

er by E. Canton, Lancet, 1848, vol. ii. p. 91; Gulliver, M. C. T. aynes Walton on the Operative Surgery of the Eye, p. 502.

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V. VEGETABLE PARASITES.—We do not attempt to give an account of entozoa and parasites generally, but solely of the surgical treatment which some of them render necessary. We therefore omit all account of *lice*, of intestinal worms, and of the *Trichiniasis*, which has created so great a panic, and which has been so ably described by Dr. Althaus.* Also, amongst vegetable parasites, we omit any account of such as cause ringworm, baldness, pityriasis, &c., and refer only to the FUNGUS DISEASE of India, described by Professor H. V. Carter, of Bombay.† In this curious disease, it appears that the sporules of some fungus find their way beneath the cuticle of the foot, then increase, and form tumours, then abscesses, and at last go on and invade the bones, which they excavate and fill with rounded black masses of fungus. The disease affects natives of India only, and seems to be irremediable except by amputation.

CHAPTER VIII.

POISONS CONTAINED IN DEAD HUMAN BODIES, POST-MORTEM AND DISSECTION WOUNDS.

DURING the decomposition of animal matter, a number of complex substances are formed, which have a most deleterious effect if introduced into the blood of living animals. If inhaled, and especially if inhaled continuously, as they used to be in the dissecting-room, they are capable of producing sickness, dyspepsia, diarrhœa, nauseous taste in the mouth, and other symptoms indicative of the presence of deleterious miasmata in the blood. But these poisons are usually quickly eliminated, and their effects removed by fresh air, aperients, and stimulants. Sometimes also by inhalation,‡ but more particularly, if inoculated, they produce most disastrous effects in the form of inflammation of the lymphatics (See Part III. Chap. IV.), and of diffuse cellular inflammation, with pyæmia. We have already spoken of the latter maladies, generally; now we propose to describe them more particularly as they occur from dissection wounds, remarking that the bodies of persons who have died from disorders of an erysipelatous nature, or from puerperal fever, are pre-eminently contagious, and much more dangerous than bodies usually are from mere putridity. The common

* Med. Times and Gazette, 1864, vol. i.

† On Mycetoma or Fungus Disease. Trans. Med. and Phys. Soc. Bombay. No. vii., 1862.

‡ Travers gives two cases. A Mrs. Clifton died of diffused cellular inflammation following a prick. Two of her attendants became ill from the contact and effluvium of the discharge, although neither had any wound through which a poison might be inoculated. One of them suffered from acute fascial inflammation of the arm; the other from low fever, and abscess in the axilla. The latter was engaged in unfolding some sheets from which a most noisome smell proceeded, when she was all at once seized with sickness and faintness, and excruciating pain in the axilla.—*Constitutional Irritation*, p. 373, 3rd ed. See also Tyrrel's edition of Sir A. Cooper's Lectures, vol. iii.; Nunneley on Erysipelas; Copland's Dict. p. 304.

and extensive use of antiseptic injections in the dissecting-rooms of late years has very much diminished the danger from this cause to the dissector. It now rarely happens that unpleasant symptoms occur. Many have been daily in the habit of dissecting for many years, and frequently cut and punctured, without ever having a bad symptom. In almost all cases where symptoms do occur, the subject of them has been reduced in health previously. Post-mortem wounds, where the bodies are fresh, and the poisons they may contain are in full action, are much more dangerous.

SYMPTOMS.—Supposing the patient have infected his finger through a wound (which is in most cases so slight as to pass unheeded), at a period varying from six to eighteen hours subsequently, he feels altogether unwell: he is depressed, faint, and chilly, and complains of lowness of spirits and nausea. These symptoms are soon succeeded by rigors, severe headache, and vomiting; the pulse is frequent and sharp, but weak; the tongue is coated, and there is the greatest restlessness and despondency. Then the *first local symptom* appears in the form of a most excruciating pain and tenderness of the shoulder, corresponding to the hand that was wounded. And in some cases there soon afterwards arises a pustule or fester, on or near the wound. But this may be unattended with any pain, and the patient may be ignorant of its existence, or may not even be aware that he has received a wound, till his attention is directed to it by his attendants. As the case proceeds, the pain in the shoulder becomes more excruciating, and is attended with fulness of the axilla and neck; and a doughy swelling appears on the side of the trunk, often extending from the axilla to the ilium. At first it is pale; but it soon assumes an erysipelatous redness, or rather a pinkish tint, like that of peach-blossoms. The breathing now becomes difficult; the pulse quicker and weaker; the tongue dry, brown, and tremulous; the mental distress is truly appalling, although there is seldom delirium; the countenance is haggard, and the skin yellow; and the patient often expires before the local disease has made further progress.

VARIETIES.—1. In one small class of cases, the influence of the morbid poison is so virulent that the patient actually *dies of the precursory fever*, before sufficient time has elapsed for any local disease to appear—either in the axilla, or in the wound, or elsewhere. The most speedily fatal case on record, that of Mr. Elcock, was of this variety. He died in forty hours from the receipt of the dissection wound; and the nervous commotion and mental despondency which he suffered were even parallel to those of hydrophobia. Dr. Bell, of Plymouth, died in the same manner. 2. In another class, diffuse cellular abscesses occur in several remote parts—the knee, or elbow, for instance, as well as in the axilla, as in the case of Mr. Shekelton.*

* The case of Dr. Bell may be found in Butter on Irritative Fever. Those of Mr. Elcock and Mr. Shekelton are quoted at length (with many others) in Travers on Constitutional Irritation. See also a paper by Mr. Adam, in the Glasgow Medical Journal, August, 1830; Stafford in Med. Chir. Trans. vol. xx. 1836.

3. In other cases the wounded finger inflames violently purates or sloughs; or the diffuse inflammation begins at the extends up the arm, or an attack of cutaneous erysipelas a the mischief in the subcutaneous tissue.

4. In a fourth class, inflammation and abscess of the lym sels and glands may be superadded.

TERMINATION AND CONSEQUENCES.—If the case do not fatally at an early period, extensive and foul collections of m in the parts that have swelled; and abscesses continue to ga the skin, or between the muscles of the trunk and limbs: these the patient may slowly sink;—or, if he survive, hi may be a mere burden; one or more of the fingers may peri grene, the arm may remain stiff and useless, or the seeds of tion or dropsy may be left in the system.

MORBID ANATOMY.—The morbid appearances are th various grades of diffuse cellular inflammation. The followi quoted as a fair description of an advanced stage.* The *cutic* the affected side of the trunk, vesicated and wrinkled;— mottled and gangrenous in patches;—the *subcutaneous cellu* in some parts distended with serum, in others, softened a with pus; the *tissue between the muscles* of the trunk, as we which separates the different muscular fasciculi, also softened lent;—the *muscular fibres*, of a dirty yellow colour, and softe *axillary glands* enlarged, but not suppurating;—the axill and *nerves* healthy;—but the *veins* (especially the smaller dirty red, and softened;—the brachial and median-cephalic v wounded arm, slightly red, but the fore-arm healthy; and n *tion whatever to be discovered between the abrasion on the the morbid parts in the axilla*;—the *pleura* of the affected si inflamed;—the lung covered with lymph, and much serum e the cavity of the chest.†

TREATMENT.—This is identical with that of erysipelas an (See p. 67.) The indications clearly are, to eliminate the po the blood; to support the strength; and to relieve pain and the discharge of pus or sloughs. First purify the blood by calomel and by enemata, bearing in mind the experiments o and Cruveilhier, in which dogs, into whose veins putrid pus injected, recovered on passing black and fetid evacuations.‡ must be quenched with lemonade, soda-water, and effervescing beef-tea, and other forms of nourishment, be liberally given brandy, or beer, be administered in sufficient quantity to su pulse; opium, to render the patient unconscious of his se This should be given in a full dose at bed-time, and in sm

* Abridged from the case of Mr. Young, in Duncan's paper in the Med. Chir. Trans. vol. i. Quoted also in Travers, op. cit.

† Dr. Law, in a valuable paper in the Dub. Med. Journal, Nov. several cases of glanders and diffuse cellular inflammation mistake rheumatism.

‡ Quoted in Ferguson on Puerperal Fever, p. 54.

he day. Quinine in large doses, or some other form of and mineral acids in the latter stages are indicated.

Treatment.—So soon as pain is first experienced in the axilla, opy fomentations should be applied. But so soon as any dis- ling can be detected, an *incision* should be made into it,—in relieve pain and tension, and to prevent the diffusion of serum at may have been formed in the meshes of the cellular tissue. are the *sine qua non* of the treatment; the point on which mainly depends: and it is most truly observed by Mr. Stafford, most of the cases that have hitherto occurred, if swelling or rmed, and were not opened, the result was fatal.

patient survive, he should as soon as possible be removed into try, and be put on a course of tonics and liberal diet. All the s of matter, which sometimes continue to form for months, e opened as soon as they are detected; and the ulcers that e dressed with stimulating lotions and bandages.

AUTIONARY MEASURES.—We need scarcely comment on the ty of using some precautions in performing post-mortem exa- s, especially if the operator be out of health, or if the patient d of any disease of an erysipelatous character. Scratches on rs, and hangnails, should be covered with adhesive plaster or , or be touched with the nitrate of silver to form an eschar, nutive hands should be well smeared with lard. If the operator unctures himself, or should suffer a scratch or abrasion to come ct with the fluids of the subject, he should immediately wash , and thoroughly suck the wound. Then the nitrate of silver e applied to it, in order to decompose the poison and excite a flammation, which will prevent imbibition.

CHAPTER IX.

CTS OF POISON GENERATED BY DISEASED ANIMALS.

SECTION I.—HYDROPHOBIA.

TION.—Hydrophobia is a disease caused by inoculation with the f a rabid animal, and characterised by intermitting spasms of cles of respiration, together with a peculiar irritability of the d disturbance of the mind.

PTOMS IN THE DOG.—Since prevention is better than cure, it desirable that every medical practitioner should know the symp- f rabies in the dog, and most especially the earliest symptoms. according to Mr. Youatt, are "unusual sullenness, fidgeting, tinual shifting of posture." The dog retreats to his basket or several hours, where he lies curled up, with his face buried be- his paws. Then he becomes fidgety, continually changing his

with his usual expression of discontent. Then comes a pause,—a moment of actual vacuity,—" the eye slowly clo droops, and he seems as if his fore-feet would give way an fall; but he springs up again, every object of terror once rounds him, he gazes wildly around, he snaps, he barks, an again to the end of his chain to meet his imaginary foe."

The amount of *ferocity* displayed by rabid dogs varies Some there are whose fury knows no bounds, and who, if out, biting every man and beast in their way. Others, c trary, not only cannot be made to bite, but, in the very e of the disease, show an *increased fondness*, and are perpet to lick their owners' hands and face. Many cases are o persons who have been thus infected through some accide or abrasion; and hence when rabies has been detected in most important to inquire whether any persons have scra he may have licked, and if so, these should be cauterized at

Another early and constant symptom of rabies is *cha* Every sound uttered by a rabid dog, says Mr. Youatt, is changed. But there are two sounds, in particular, that des one of which is described as a " a hoarse inward bark, with vation of tone;" and the other a most peculiar and charact bination of " a perfect bark, ending abruptly and very sin howl, a fifth, sixth, or eighth higher than the commencemen

Other symptoms, observed at the commencement of the loss of appetite, propensity to lick cold surfaces, such a iron, and to devour straws, litter, and similar rubbish; a eagerness, in scenting at and licking not only the comm places, but corners in rooms that are not usually disgrac evacuation. This is considered a highly-important sympt is no *dread of water* as in the human being; on the cont satiable thirst, which the dog endeavours to allay by lapp as he has power over his jaws. The mouth is dry, and th

viscidity of the saliva, to which may be added perfect insensibility to pain. As it approaches its termination, the eye becomes dull; the hind legs first, then the muscles of the jaws are paralyzed, and at length the poor animal dies exhausted.

But there are some cases in which paralysis of the muscles of the mouth and jaws is a very early symptom; the mouth being open and the tongue protruding. A poor dog in this condition will plunge his muzzle into water up to the very eyes in order that he may get one drop into the back part of his mouth to cool his parched throat. This form of the disease is generally called *dumb madness*.

The usual *duration* of rabies is from four to six days.

The post-mortem appearances show merely the *effects* of the malady, in various degrees of congestion of the mucous membrane of the respiratory and alimentary surfaces. The *tongue*, often torn and bruised, and covered with filth; its papillæ prominent and reddened, the mucous follicles about the frænum enlarged. In the *dumb madness*, the tongue hangs from the mouth, and is swelled and dark-coloured. The fauces show a more or less partial blush, and the epiglottis and larynx are usually much injected. The trachea, bronchi, and lungs are sometimes much congested, sometimes the reverse. The stomach generally shows vivid redness, or sometimes patches of ecchymosis on the summit of its rugæ; the brain, intestines, bladder, and heart display no appreciable or constant morbid signs whatever. Perhaps one of the most characteristic evidences of rabies that dissection affords is the presence of a peculiarly-mingled mass of hay, and hair, and straw, and earth, and excrement in the stomach, or perhaps in the fauces, where it may have lodged from defect in the power of deglutition.*

CAUSES.—The cause of this malady in dogs is most frequently a bite from another animal already diseased; yet it seems occasionally to arise spontaneously. It has been ascribed to close confinement, rank unwholesome food, want of the *couch grass*, the natural medicine of the dog, and deprivation of sexual intercourse.

It has epidemic fits of prevalence, and has been very severe in Liverpool this year, 1864.

Besides the dog, hydrophobia infects the wolf, jackal, badger, and cat. But it may be communicated to many other mammiferous animals, and there is no doubt but that every animal capable of taking the disease can also propagate it. This is equally true with regard to human beings as to animals. MM. Magendie and Breschet inoculated two healthy dogs on the 9th of June, 1813, with the saliva of a man who was labouring under the disease, and who died of it the same day at the Hôtel Dieu. One of the dogs ran away, but the other was affected with decided rabies on the 27th of July following, and died of it; and some other dogs, which it was made to bite, died also. Well-authenticated cases are recorded, in which the disease was communicated to man by pigs and horses; and there is no doubt but that it would be so much more frequently, if it were the instinct of herbi-

* See *The Dog*, by W. Youatt, Lond. 1845.

profuse sweating; he soon becomes frantic and outrageou
snorting, and kicking.† In the *sheep*, the symptoms are s
instance is recorded in which eight sheep were bitten,
rabid: they were exceedingly furious, running and butti
person and thing, but did not bite. They drank freely.‡

There are several points connected with the propagatio
phobia which are still involved in great uncertainty. It is
whether the saliva is the poisonous agent, or whether som
matter may be secreted by the mouth, fauces, or lungs,
with it. This, however, is not a point of much conse
again, it is uncertain whether the whole solids and fluids o
are not poisonous also. In fact, there is some reason f
that the disease may be communicated by the mother's mil
over, it appears that it may be communicated by contact
saliva with the skin, or mucous membrane, without an
abrasion.‖ In a case related by Dr. Watson,¶ the dog's t
indented the skin of the back of the hand, but made no woun
a point of more importance and uncertainty than any is,
bite of an animal in health, or of one merely enraged, ma
the disease: it is very certain, at all events, that the
animal will prove fatal long before it exhibits any outwar
of rabies.

Symptoms in Man.—At a variable period after a b
some other mode of inoculation with the saliva of a r
(which period is generally from five weeks to three months
much longer, possibly even one or two years), the atten
patient is directed to a peculiar pain of the wounded pa
with slight heat, redness, and swelling. The pain is obser
in the course of the nervous trunks, and has in general
character. Sometimes, instead of it, there is a stiffness o
or partial palsy. In some cases it is unattended with redn

ing; in others, on the contrary, the wound has thoroughly inflamed, and has broken into suppuration afresh, although healed long before. In some instances these premonitory symptoms have not appeared at all, or have been so slight as to pass unheeded: in a few instances they have not appeared till after the accession of the genuine hydrophobic symptoms; but in general they are observed from two to five days previously to the actual symptoms of hydrophobia. Of these, the first is a vague feeling of uneasiness and anxiety. The patient finds himself generally unwell; his mind is irritable, and his countenance gloomy; he experiences a succession of chills and flushes with transient headache; the appetite fails: there is frequently vomiting, and sometimes a well-marked accession of fever. Next, the sufferer complains of stiffness of the neck and soreness of the throat, with severe spasmodic pains at the epigastrium; the respiration also is embarrassed, and frequently interrupted by sighing. But these symptoms are in most cases attributed to cold, and their real nature is not suspected for a day or two, till, on a sudden, on attempting to drink, the patient is seized with a fit of suffocating spasm, and manifests extreme horror at the sight of fluids.

The most prominent symptoms that henceforth present themselves, are three, viz., difficulty of breathing and swallowing, extreme irritability of the body, and peculiar disorder of the mind.

(a.) The *difficulty of breathing and swallowing* depends on spasm of the muscles of the pharynx and larynx. Sometimes the patient can swallow neither solids nor liquids, but more frequently the disability extends to liquids only; because they require a greater exertion of these muscles, and are consequently more liable to excite spasms. It is this circumstance that causes the aversion to fluids, and the alarm at the sight of them, which so generally characterise the disease. At first the spasms are excited only by attempts to swallow fluids; then they are brought on by the sight or thought of them; or by the motions of spontaneous deglutition; but as the malady advances, they recur in frequent paroxysms—sometimes spontaneously, sometimes excited by the slightest noise or touch. When the paroxysms have become fully developed, they cause the most frightful struggles for breath. All the muscles are convulsed, the face is black and turgid, and the eyeballs protrude from their sockets. They may come on either during inspiration or expiration, but more frequently the latter; the patient struggling most violently to expel the air that is confined in his chest through the closure of the larynx. In this disease, as in tetanus, the fatal termination may ensue from suffocation in the middle of a paroxysm, although it more frequently happens during an interval, from exhaustion.

(b.) Next to the spasm, the astonishing *irritability of the surface of the body* is the prominent symptom of hydrophobia. The slightest impressions on the senses affect the sufferer most intensely. A look, or a sound; the opening and shutting of the door of his apartment; the motions of his attendants; the reflection of light from a mirror; the

least impression on the skin; the touch of a feather, or impulse of the gentlest current of air, are sufficient to bring on the convulsive fits, and are most earnestly deprecated by the patient.

(*c.*) The *state of mind* is in most cases one of most profound despair. Sometimes there is great restlessness and talkativeness; sometimes maniacal fury; more rarely entire composure and tranquillity throughout the disease.

PROGRESS AND TERMINATION.—When the disease is fully established, its torments are aggravated by extreme thirst; and still more by a peculiar viscid secretion from the fauces, the irritation of which brings on the convulsive fits, and causes a perpetual *hawking* and spitting, which are very constant symptoms. Not unfrequently there is vomiting of greenish matter mixed with blood. As the disease advances, the convulsions increase in frequency and violence; there is constant restlessness and tremor; the lips and cheeks become livid, and perpetually quiver; till at length one fit lasts long enough to exhaust the remaining strength, and release the patient from his misery. An entire and remarkable remission (perhaps from the use of medicine), sometimes occurs, and the patient enjoys perfect ease, or perhaps sleeps for some hours; but yet the symptoms return, after a time, with aggravated violence. Again, in some cases, there is a perfect calm before dissolution; "the patient becomes tranquil, and most of his sufferings subside or vanish; he can eat, nay, drink or converse with facility; and former objects associated with the excruciating torture of attempting to swallow liquids no longer disturb his feelings. From this calm he sinks into repose, and, suddenly waking from his sleep, expires."*

MORBID ANATOMY.—The morbid appearances most frequently found are, congestion of the membranes and substance of the brain and spinal cord, and effusion of serum. Sometimes blood is extravasated around the cervical portion of the cord. The lining membrane of the fauces, œsophagus, trachea, and bronchi, are most highly vascular, the papillæ at the root of the tongue large, and the lungs congested. The stomach often contains a darkish fluid, and patches of vascularity of a dark-purple colour are found in it and in the intestines. But although some one or more of these morbid appearances are detected in most cases, still there is not one of them that is present invariably. The brain, spinal cord, and fauces have been found pale, and the stomach without spots. Hydrocyanic acid has been detected in the blood after death, but this is not peculiar to hydrophobia.†

PATHOLOGY.—It is quite clear, therefore, that no change of structure that has yet been discovered can be considered essential to the existence of hydrophobia. It is true that the difficulty of breathing and swallowing may be partially accounted for by the inflammation about the fauces, and the great irritability of the surface is symptomatic of irritation of the spinal cord. But still no mere local changes can

* Bardsley, Cycl. Pract. Med. *Art.* Hydrophobia.
† Med. Gaz., 5th September, 1840.

explain the mass of symptoms, which must depend on a peculiar change in the blood, or nervous system, or both.*

Diagnosis.—The chief diagnostic signs are the spitting, and especially the influence of slight currents of air in bringing on the convulsive attacks. In July 1854, the writer saw a case with his friend Dr. Challice of Bermondsey. The patient, a middle-aged woman, had been bitten in the foot by a cat in the April preceding. She was lying in bed, rational and tranquil, and nobody could have seen at the first glance that she ailed much. The writer took her hand to feel her pulse; and whilst doing so, breathed on it as gently as possible. Instantly the poor woman started up in bed choking with spasm in the throat. This was sufficient for the diagnosis.

Preventive Treatment.—As soon as possible after the bite of a suspected animal, the whole wound should be sucked, and so soon after as may be, should be excised or cauterized, or both. Mr. Youatt recommended the *nitrate of silver;* and he certainly had a right to speak in favour of it, since he was bitten many times, and escaped, though he used no other preventive; and since he gives instances in which out of several animals bitten by the same dog, those which were cauterized by the nitrate of silver escaped all further mischief, whilst some which had the wound excised, or cauterized with a hot iron, were subsequently infected with rabies. These are certainly strong facts in favour of using the nitrate of silver; but cases have occurred in which the immediate and free application of it was useless.

The rule generally given, however, is that the bitten part should be cut out, care being taken to carry the knife wide of the bite. After this, bleeding should be encouraged by the application of a cupping-glass; or the wound should be long and diligently washed in warm water. And then (especially if the bite has been irregular, so that it is uncertain whether the excision has been complete) the raw surface may be cauterized by the nitrate, or by nitric acid; or by caustic potass. Chloroform will aid the surgeon in carrying out these disagreeable processes coolly and efficiently.

When we consider that substances introduced fairly into the blood may find their way all over the body in an inconceivably short space of time (probably in nine seconds†), it will be readily seen that excision or cauterization, although performed as soon as possible after the bite, may be of no avail. Yet they *should never be omitted, let the interval be what it may.* And one case is recorded in which it is said that the patient was saved although the parts were not cut out till the thirty-first day, and not till the symptoms had actually made their appearance. This, however, is doubtful.‡

* A case of *real* hydrophobia, supposed to have occurred without any infection, is quoted from the Trans. of the Coll. of Phys. of Philadelphia, in Prov. Med. Journ. for 1850, p. 225. But if the poison can be so readily imbibed, as we have shown, through a slight scratch, or through the unbroken skin, it is more probable that the disease in this case arose from infection, unsuspected, than that it was of spontaneous origin.

† Blake, Edin. Med. and Surg. Journ., Jan. 1840.

‡ Thompson, Med. Chir. Trans. vol. xiii., and Lancet, Sept. 23, 1837.

CURATIVE TREATMENT.—Here we are met at the c
doubt whether hydrophobia can be cured at all; whe
plague and small-pox, it will not run its course, without
of checking it. Mr. Youatt says that he believes he h
prevented it in the dog, and that he has occasionally
spontaneous recovery; but that he has never cured it.
believes that the premonitory symptoms may show then
and the disease go no further. But although it cannot
a few rare cases have recovered, or have been reported
for instance, one after enormous bleeding; one from viole
one from the use of lead in large doses;† still the reme
supposed to be successful in these cases have been u
again in others without benefit.

Pages might be filled with an account of the remedi
been resorted to in vain. Bleeding, which is quite ina
injection of warm water into the veins, which in Ma
certainly proved a palliative; opium, which sometimes
rary relief; Indian hemp:—of all which it may be said,
they may mitigate the patient's sufferings, yet, that the
to have in it some source of mortality quite independent
local symptoms, and not to be neutralized by any reme
our reach.

In the present state of our knowledge, the principa
allay the patient's sufferings. This should be done by
perfectly quiet, and in the dark; by the very gentle
administration of chloroform, by food per anum, stimu
to the spine by means of Dr. Chapman's bag. For
we may refer to the Chapter on Tetanus, with whic
has the closest analogy.

SECTION II.—THE GLANDERS.

DEFINITION.—The glanders is a disease of the horse

SYMPTOMS IN THE HORSE.—It may occur in two forms, which, however, are merely manifestations of the same disease in different parts. When seated in the *lymphatic system*, it is called *farcy*—when in the *nasal cavities*, *glanders*. But these two forms are essentially identical: the pus of either of them will reproduce the other; and farcy always terminates in glanders, if the animal live long enough, and its progress is not arrested.

Farcy begins with hard, cord-like swellings of the lymphatic vessels and glands, called *farcy-buds*. These slowly suppurate, and form unhealthy fistulous sores, which discharge a copious thin sanious matter.

If suffered to proceed unchecked, farcy leads to glanders, although more frequently the latter arises first.

Glanders.—Its symptoms are, a *continued* flow of discharge from one or both the nostrils (generally the left), which discharge is at first thin and serous; then thick and glairy, like the white of egg; but after a time becomes opaque, purulent, bloody, and horribly offensive, retaining, however, its viscidity. Soon after it commences, an enlarged gland may be felt under the lower jaw adhering to the bone. The next things noticed are one or more ulcers on the Schneiderian membrane, having the sharp edges and scooped-out character of chancre; these spread widely and deeply, and lead to caries of the bone. Then the lips and eyelids swell, and the conjunctivæ suppurate; and the external parts of the face may become gangrenous, and the animal may die in a few days with putrid fever; or he may perish more slowly;—the disease spreading to the lungs, and death being induced by cough, emaciation, hectic, and the formation of unhealthy abscesses in the lungs and all over the body. The *distinctive symptoms*, according to Youatt, are the *continuousness* of the discharge, and the adherence of the enlarged submaxillary gland.*

SYMPTOMS IN MAN.—This disease may appear either as glanders or farcy; either of which may be acute or chronic.

(1.) The *acute glanders* begins with all the symptoms that indicate the absorption of a putrid poison. There are general feelings of indisposition, lowness of spirits, and wandering pains; followed by fever, furred tongue, great thirst, profuse perspirations at night, great pain in the head, back, and limbs, and tightness of the chest. After some days these symptoms increase: there are severe rigors and delirium, often of a phrenitic character; the perspirations become more profuse, and sour and offensive, and are attended with diarrhœa of a similar character. Then *diffused abscesses* appear in the form of red swellings about the joints, especially the knees and elbows—the patient complains of heat and soreness in the throat; the tongue becomes dry and brown, the respiration more oppressed, and the fever assumes a decidedly low malignant character. Next (perhaps a fortnight from the commencement of the illness, sooner or later in different cases) a dusky shining swelling appears on the face, especially on one side,

* Blaine, op. cit.; Youatt on the Horse.

extends over the scalp, and closes the eyes. Then the cha features of the disease appear;—an offensive, viscid, yello charge, streaked with blood, issues from the nostrils; and large and remarkably hard pustules (compared by some to th small-pox, and said by others to be about the size of a pe on the face. In the meanwhile the swelling and infl increase;—a portion of the nose or eyelids mortifies;—the becomes more and more profuse and offensive;—the pustul and extend over the neck and body; fresh abscesses form a rate; the thirst is most excruciating; and low murmuring and tremors usher in death—much to be wished for.

(2.) The *chronic glanders* is characterised by a viscid a liarly fœtid discharge from one nostril, with pain and swelli nose and eyes;—and emaciation, profuse perspiration, and near the joints, from which the patient slowly sinks.

(3.) In the *acute farcy*, the patient receives the poison t wound or abrasion, which inflames violently, together with phatics leading from it. The symptoms are attended with able fever, and are generally soon followed by the diffused pustular eruption, and nasal discharge, that characterise acute

(4.) In the *chronic farcy*, a wound poisoned by glanderou degenerates into a foul ulcer; the lymphatic vessels and gla and suppurate; abscesses form in different parts of the body the disease is not cured, or does not destroy the patient first, nates in acute glanders.*

CAUSES.—In the horse this disease may, without doubt, a taneously, when the animal is subjected to the usual influe generate putrid poisons;—namely, insufficient and unw food, close confinement, and ill ventilation, especially on bo Mr. Youatt believes that it may arise, if the animal is kept state of health, as the climax of constitutional weakness and ment. In man, it is generally produced through inoculatio matter into a wound; and the matter from the abscesses cavities of human beings is capable of communicating the dis to men and animals. A man died of glanders in St. Barth Hospital, in 1840, and the nurse who attended him inocul hand, and died of it also in a very few days; and two kitt were inoculated from the nurse, became affected likewise. M the blood of a glandered horse injected into the veins of a he communicated the disease, although no abnormal appearance

ATOMY.—The morbid appearances are the same both in
horse. Clusters of white granules, or tubercles, or, as
scribes it, of matter like putty or thick pus, are found in
the disease has invaded; in the Schneiderian mem-
antrum and frontal sinuses, and in the vicinity of the
ses. The nasal cavities mostly contain a thick brown
tion, and are studded with foul gangrenous ulcers, from
fungous clusters of tubercular matter.
T.—The chief points are, to open all abscesses as soon as
yringe the nasal cavities with solutions of creosote, or
and to support the strength and abate the thirst with
and soda-water, beef-tea, &c. The effluvia must be coun-
inigations of chlorine and aromatics. In fact, in every
age of this horrible disease, the strength must be kept up,
ious discharges neutralized. Creosote injections, the admi-
oiide of potassium with iodine, and mercurial salivation,
es respectively are said to have effected cures.*

CHAPTER X.

ON VENEREAL DISEASES.

SION I.—GENERAL HISTORY AND PATHOLOGY.

ON.—By venereal diseases, we understand the effects of
al poisons, usually communicated by sexual intercourse.
me *venereal* by no means implies that sexual intercourse is
e by which these poisons can be disseminated. As Astruc
venereal disease may be communicated from the infected to
t in one only, but in several different manners, as often as
continued contact, the soft tender warm and moist parts
nt persons mutually heat each other."†
s.—The diseases which are called venereal, are now arranged
eads:—1st. *Gonorrhœa*, which is an inflammation and sup-
the mucous membrane of the male or female genitals. It
unicated by means of the pus, to other mucous membranes,
ly the conjunctiva. (See p. 33.) 2ndly. The *chancroid*

ason's papers in the Med. Chir. Trans. vols. xiii. xviii. (*with a*
) and xix.; the Med. Gaz. vol. xix. p. 939; case communicated
son, Lancet for 1831-32, vol. i. p. 698; Rayer, de la morve et du
humme, Mém. de l'Acad. de Méd. 1837; the cases of the patient
St. Bartholomew's Hospital above quoted, in the Lond. Med. Gaz.,
d 25th, 1846; case of acute glanders cured by injections of creosote
Lancet, April 20th, 1839; case of acute farcy cured by iodide of
h iodine, Arch. Gén. de Méd., Jan. 1843; Yonatt's book on the
Burgess's Translation of Cazenave on Diseases of the Skin, Lond.
reated by mercury, recovery; Mr. Carpenter of Croydon, Med.
, 1845.
of Venereal Diseases, Lond. 1754, preface.

ulcer, soft chancre, syphiloid, local syphilis or *non-infecting* is a highly contagious suppurating ulcer, capable of bein in almost unlimited succession, on the same patient;—but the best observations, it is a local disease; it produces an ever inoculated, with probably suppurating bubo, *i.e.*, su the nearest lymphatic ganglion, but *no secondary sympto* The *true syphilis*, true *chancre, Hunterian chancre, hard, i infecting sore*. This does not usually produce such formida or immediate symptoms as the soft chancre. Mr. Henry monstrated that it does not yield *pus*, but generally only and serum; there may be no loss of substance at all, rati trary; the constructive may surpass the destructive element (See p. 69.) Whilst the "soft" chancre may stand as th true spreading ulcer, the "hard" may be a little raised with epithelial hypertrophy, more like a small speck of ps an ulcer. It produces also, not a suppurating bubo, but multiple enlargement of the chain of nearest lymphatic gan rarely suppurate. That which distinguishes this third form gives rises to a peculiar constitutional diathesis;—when fully it cannot be multipled by inoculation on the same patie causes what are called *secondary* and tertiary, or constitut toms;—that is, a general infection of the system, whic merly known as *lues venerea*, or *confirmed pox*, and which, justly says, ought to be considered the real disease—the p being the mere point of introduction.

Disputed Questions.—This will be a convenient plac dering several disputed questions as to the history, origin, an these diseases, and for referring the student to authors fro may obtain fuller information than our pages have room for. have arisen on the questions—1. Were venereal diseases kn ancients? or are they peculiar to modern times? 2. If mo they imported from America? 3. Can any theory be framed origin, and as to the number and nature of the poisons by are caused?

1. The latest researches seem to show that the persons who c venereal diseases were known to the ancients, and those wh opposite line, are each right and each wrong, in a certain sen can be no doubt but that gonorrhœa was well known in Eng middle ages, under the terms *brenning, burning, ardor*, For example, in the regulations for the *stews* of the borough

ota (1276), Lanfranc of Milan, John of Gaddesden, Doctor of
in the University of Oxford, and author of a Treatise called
Rosa Anglica, and Guido de Cauliaco, all flourishing before the end of
fourteenth century, describe ulcers, imposthumes, bubo, and pus-
arising from commerce with foul women. Moreover, the ex-
of maladies which could be contracted and propagated by sexual
ourse is proved beyond all possibility of doubt by regulations
public stews such as those we have just referred to. Our fore-
were far too wise to allow loose women to parade the streets,
new disease broadcast, as we do in these modern Protestant moral
equally were they too wise to attempt to suppress fornication
ther. But they shut up their loose women in stews or brothels,
them under strict surveillance, including periodical medical ex-
ions, to make sure against contagious disease. The Statutes of
ew, at Avignon, established by Jane Queen of the Sicilies and
ss of Provence, in 1347, enact, "that a public brothel should be
at Avignon, and the wenches who ply there shall not walk
eets, but keep within the brothel, and wear a red knot upon their
oulder. * * The door to be kept locked, and no young man
ld without leave of the Abbess. * * That on every Saturday
omen be singly examined by the Abbess and a surgeon, and if any
m have contracted any illness by their whoring, that they be
ol from the rest, and not suffered to prostitute themselves, for fear
th who have to do with them should catch their distempers."*
hat it is thus clear that some disorders existed in ancient times,
could be got from venery, and which we believe to have been
d with the gonorrhœa, and possibly with the *soft* or non-infect-
venereal ulcer of the moderns—a disease which is formidable
if we remember its phagedænic varieties—it is equally clear
new element appeared on the stage of modern civilized life be-
the years 1494 and 1496, amongst the soldiers who were occu-
nder King Charles VIII. of France in besieging Naples. There
doubt but that this disease was *new* to the physicians of Europe,
y all declared that they had seen nothing like it before, and
ghast in ignorance how to treat it. Fallopius, who wrote about
ears after its introduction, distinctly recognizes the diseases
to the ancients, and the new disease. The ancients, he says,
their times ulcers arise about the pudenda, which they called
; for writers before the venereal disease appeared, as Guido,
m them as arising from a person not cleansing the glans, or
his having to do with a woman that was menstruating. But
affirm, he continues, that there is the greatest difference be-
the French Pox (*Caries Gallica*) and these Heats. "True
chancres are to be distinguished from the others. Heats,
ations, &c. are easily cured;—venereal ulcers not so quickly."
new disease evidently spread with great rapidity over the
world, and was everywhere recognized, and received names

* Quoted in Astruc, op. cit., p. 60.

as a new and imported disease. The French called it the Neapolitan Disease; but the Italians, and Germans, and English called it the French Disease; the Dutch, who seem to have got it from the Spanish who then were in force in the Low Countries, called it the Spanish Disease; the Polanders called it the Disease of the Germans; and the Russians the Disease of the Polanders; the Portuguese called it the Castilian; the East Indians, Portuguese; the Chinese called it the Canton Disease; the Turks called it the Disease of the Franks (*i.e.* of the Christians); and the Persians the Disease of the Turks. Its spread over Europe is traced by the writings of physicians, and by the regulations of municipal bodies. The parliament of Paris issued regulations of the most stringent sort, so early as March 6th, 1496, that is, within two years of its appearance at Naples, commanding all persons infected with the *grossa variola*, or Great Pox, to quit the city, and repair to a house provided for their reception at St. Germain les Prez. Dr. Simpson has given an account of the regulations established in Scotland in 1497 against the French Pox. The first medical author who wrote of it was Grundbeck, in 1496, *De Pestilentiali Scorra, sive Mala de Franzos.** No fewer than thirteen other writers are enumerated whose works on the Morbus Gallicus are extant, and were published at Venice, Rome, Bologna, Leipsic, and Heidelberg, before the end of the year 1500. The first Englishman who published a book on it was William Clowes, in the year 1575; but before him, about 140 authors had written on the Continent, of whom about twelve were French, the remainder chiefly Italian and German. The name *Syphilis* was an invention of Fracastorius, who wrote a Latin poem *De Morbo Gallico*, about the year 1520, and published it in 1536. He feigned that a shepherd named Syphilus was first infected with it through the anger of Apollo. The early writers recognized many ways in which the disease could be propagated; thus Fallopius says: "It affects certain particular parts of men's bodies such as first touch those of others therewith infected; whether the pudenda as in copulation; the lips, as in kissing or sucking; the nipples, by giving suck to an infected infant; and the infant by means of the distempered nurse receiving such infection from the nipple." Amatus Lusitanus (1552) gives the case of a man, "who ten years after an infection from which he believed himself cured, married a healthy woman by whom he had two healthy children; but some years after marriage she brought him a son, in whom this disease appeared, and a little after, she had an ulcer on the side of her nose: not being able to suckle her child, she put him out to a nurse, who soon afterwards was contaminated by the child's sucking of her; the nurse infecting her husband besides two other children of

* Trans. of Epidemiological Society, vol. i., part ii., p. 144, published by Hardwicke, Piccadilly, 1862. An edict of the Town Council of Aberdeen, dated 21 April, 1497, recognises it as "*the infirmity cumm out of Franche and strang partis.*" One ten years later, calls it "*the sykness of Napils.*" Edicts were issued at Edinburgh in Sept. 1497. It was then called *Grand Gore*, also French and Spanish Pox.

her neighbours to whom she had ignorantly offered her breast in the same manner as to the first. These gave the taint to their parents, and thus nine several persons became diseased with this lues in one month's time."* If we want further evidence that a new disease invaded Europe at the end of the fifteenth century, and that this disease was true syphilis; that it was not the disease formerly known as leprosy; that it was propagated rapidly, and that its propagation was effected not merely by licentiousness, but by habits of uncleanness such as at least the upper classes of society are now free from, we may find it in the "Colloquia" of Erasmus,† written about 1520. This book contains one Colloquium between two friends, one of whom laments the marriage of a young girl to a man who was affected with a most glorious pox—*scabies superbissima*, which he says has many names, as French, Neapolitan, and Spanish Pox, and yet no proper name of its own. He describes the flattened nose, stinking breath, and lame leg of the bridegroom. He says this *lues* is worse than any kind of leprosy; for it invades more quickly, recurs more obstinately, and often kills; while leprosy often allows men to live to a good old age. This disease might be got by kissing, by whispering into the ear, by contact, and by drinking out of the same vessel. It were better, he says, to let the beard grow to the knees than to have it shaved by a man who might have dressed a poxed patient and infect you with his fingers, towels, combs, or scissors. No one ought to be surgeon and barber too. No persons ought to be allowed to drink out of the same cup. Nor ought any persons except husband and wife to sleep in the same bed. Nor ought guests in any hotel to sleep in sheets that have been used before. On which he observes that the Germans scarcely wash theirs twice a year. Kissing, even in church, should be prohibited.—Thus far Erasmus.

2. Was syphilis, *the* venereal disease *par excellence*, *imported from America*? Columbus is said to have sailed from Spain, August 3, 1492; to have reached Haiti on December 6; and to have left it on January 6, and reached Lisbon on March 6, 1493. Hence he went to Palos on March 15; whence he marched with 82 men and 9 Indians who had returned with him, to Barcelona, where the King of Spain was. On 25th September, 1493, he returned to Haiti with 17 ships and 1500 men; whence he despatched 14 ships on a return voyage to Spain in 1494. At the end of 1494, three more ships returned from Haiti, bringing with them Pedro de Margarita, a Catalonian gentleman, who has the reputed honour of having brought the pox in his own person to Europe. Ships now passed monthly each way; one is said to have arrived in Cadiz on June 11, 1496, bringing two hundred soldiers affected with syphilis. Thus the disease was communicated to Spanish women; and from them to Spanish soldiers who went to Naples to King Ferdinand II. to fight the French. Such is the account commonly given. We have no space to enter into the matter; but may observe that

* Quoted in Daniel Turner's Aphrodisiacus, Lond., 1737.
† Erasmi Colloquia, Elzevir, 1636, p. 512.

3. What is the *theory of th*
history of opinions, we find tha
forgot the separate existence of
communicated by connexion, and
taking gonorrhœa (which was s
bubo, swelled testicle, all sorts of
tional symptoms of syphilis to
requiring mercurial treatment.
sense prevailed. Thus several
be needless in gonorrhœa; Profes
cate something of modern doctrine
feared if there be a copious gonorrhœ
pronounced mercury unnecessary in
with custom.* Still it was only i
of gonorrhœa and syphilis was for
a thesis published at Edinburgh.†
diseases was fully established by
lessness and mischief of mercury in
practice to salivate in this complai
for he bitterly denounces the custo
day by the vulgar advertising qua
from syphilis may be called the fir
of these diseases.

That which delayed the genera
perhaps caused a greater amount
practice than any work ever bef
celebrated book on the Venereal
one experiment, affirmed the ide
and thus perpetuated the

"ulvers" in Scotland.* Yet it remained part of the English medical creed on Hunter's *ipse dixit*; and it was even engrained by the earlier researches and doctrines of M. Ricord. This eminent syphilographer, well represented in England by his pupil Mr. Acton, believed that every primary chancre was inoculable during a certain portion of its existence; but that secondary ulcers, resulting from general infection of the body, were not so. He believed that infants could be syphilised by transmission of the disease through father or mother to the embryo; but disbelieved the idea that any secondary sore, in other words, any sore not the result of primary inoculation, could be propagated by inoculation. It will seem incredible to another generation how these false doctrines perverted men's minds and led them to explain away the notorious facts of the infection of nurses by syphilitic children; and of other healthy children and of husbands by syphilized nurses. It was asserted, for instance, that for a child to infect its nurse's nipples, it must itself have received the contagion from a primary chancre in its mouth!†

After the non-identity of gonorrhœa and syphilis, and the reaffirmation of the contagiousness of secondary syphilis, the next great step in modern times, has been the determination of the difference between the soft or local non-infecting sore, and the true indurated syphilitic chancre. This was effected on the Continent by Bassereau, Rollet, Fournier, and Clerc, who in 1855 announced the doctrine that the secretion of an infecting sore could not be inoculated on the same subject—a theory which, as Mr. Lee says, "might have been deduced from Ricord's dogma, that a person can have syphilis once only."‡ In England the real state of things was made known by the original independent researches of Mr. Henry Lee published from time to time in the Med. Chir. Trans., British and Foreign Med. Review, &c. Mr. Lee showed in 1853 that the suppurating sore is a different disease from the indurated or infecting sore; and in 1856 that the former can readily be inoculated on the patient whilst the latter cannot. And hence we see the fallacy which beset Ricord's inoculations. A true chancre, after a few days, produces, as vaccination does, a constitutional diathesis, which renders the patient insusceptible to a fresh attack for some time—perhaps for life. Hence a true syphilitic sore, primary or secondary, cannot, under ordinary circumstances, be inoculated on the same patient. But it is a great mistake to infer, as Ricord and Hunter did, that a secondary sore cannot be inoculated on another person; in other words, that it is not contagious.

* The popular name of syphilis amongst the peasantry of certain parts of Scotland, where it had been handed down from ancestors who had got it from the Puritan soldiers of Cromwell—derived from the resemblance of mucous tubercles and florid projecting cicatrices to raspberries—identical with button scurvy of Ireland, and most likely with the African and West Indian Yaws. See Benjamin Bell, op. cit.

† See Acton's Complete Practical Treatise on Venereal Diseases, Lond. 1841. For a full demonstration of the contagiousness of infantile hereditary syphilis, see Ibbey on Infantile Syphilis, published by the New Sydenham Society, 1859.

‡ Lectures, p. 27.

4. *Plurality of Poisons.*—Having thus shown the distinction between gonorrhœa and syphilis and between the non-infecting and infecting kinds of chancre, we may ask whether the *varieties of venereal disease* depend on *variety of poisons*. We know what the poison of gonorrhœa is. It is the pus of an inflamed mucous membrane, and has nothing specific in it. What the poison of syphilis is, we know not, and may imitate Mr. Lee's philosophic caution when he says that we know not whether there be many poisons, or one poison acting in different ways.

5. Lastly, as part of the general history of syphilis, the student should know that quicksilver was brought into use by the Arabian physicians a thousand years ago as a remedy for vermin and skin disease, and that it was used, from analogy, almost upon the first outbreak of syphilis. It was at first employed by inunction and fumigation ;—afterwards internally ; but at first by very coarse and corrosive preparations. It was immensely abused by quacks ; and guaiacum and sudorific decoctions of sassafras, china and sarsaparilla, with copious sweatings, were early substitutes. There is no doubt but that mercury has done more good than any other remedy, though it was for a long time coarsely used even by regular practitioners, who caused patients to spit half a dozen pints a day. Still it has taken three hundred and fifty years of the most actively observant period of man's history, to clear up the nature of syphilis, and that during that time, although we have improved in the mode of using old remedies, we have but one new one, the iodide of potassium.*

SECTION II.—GONORRHŒA, OR CLAP.

DEFINITION.—A gonorrhœa signifies a suppuration of the mucous membrane of the male or female genitals ; produced by contagion from the pus of a membrane in the like state.

SYMPTOMS.—In the *first stage*, the patient notices a little itching at the orifice of the urethra, with a slight serous or thin whitish discharge. If the disease is not checked, it passes after a few days into the *second*, or acutely inflammatory stage. The discharge becomes thick and purulent, and when the disease is at its height is greenish, or tinged with blood. The penis swells; the glans becomes of a peculiarly cherry colour, is intensely tender, and often excoriated. In consequence of the tumefied state of the urethra, the stream of urine is small and forked, and passed with much straining and severe pain and scalding. All the parts in the vicinity of the genitals, the

* The author must record his obligations to Hennen's Military Surgery; Carmichael on Syphilis; Bacot's Treatise on Syphilis; Travers on the Venereal; Titley on Diseases of the Genitals of the Male; Judd's Treatise on Urethritis and Syphilis (Plates); H. J. Johnson, in Med. Chir. Review; Colles on the Venereal; Ricord, Traité des Maladies Vénériennes, Paris, 1839; Mayo on Syphilis, Lond. 1840; Lane's Lectures in the Lancet, 1841 and 1842; Egan on Syphilis and Inoculation, London 1853; Tyler Smith, Lancet, 1853, vol. ii. Becket's Papers on the Antiquity of Syphilis, Phil. Trans. 1714–24; Bumstead on Venereal Diseases, Philadelphia, 1864.

loins, thighs, perinæum, and testicles, ache and feel tender; and the patient's nightly rest is disturbed by long-continued and painful erections, and by *chordee*, that is, a highly painful and crooked state of the penis during erection. This arises from a deposit of lymph in the *corpus spongiosum urethræ*, which glues together the cells, and prevents their distension, so that when the penis is turgid with blood, it is bent to one part, and horribly painful.

In the *third stage*, the inflammatory symptoms and chordee abate, and a muco-purulent discharge is left, which, when obstinate and thin, is called a *gleet*.

Complications.—1. If the inflammatory stage be very severe, there may be severe *irritation* or actual *inflammation of the urinary organs*; sometimes of the deeper portion of the urethra, producing great pain in the perinæum, and spasm of the accelerators and other muscles during micturition, so as to interrupt the stream of urine, and cause the most exquisite agony,—or even complete retention of urine;—sometimes of the bladder, causing a very frequent desire to make water and great pain in doing so, which lasts for some time afterwards, together with a white mucous cloud in the urine; or there may be shivering, pain in the loins, purulent and serous urine, tenderness of the abdomen, vomiting, and other signs of severe irritation of the kidneys.

2. *Hæmorrhage* from the urethra; from rupture of the distended capillaries during violent erection. The loss of blood generally gives relief.

3. Inflammation and obstruction of the *mucous follicles* of the urethra, which may suppurate and burst either into the urethra or externally or both.

4. *Inflammation of the lymphatic glands* of the groin, constituting *sympathetic bubo*.

5. *Balanitis* (βάλανος, *glans*), see p. 206.

6. *Phymosis*, or *paraphymosis*, owing to the swelled condition of the glans and prepuce. When the latter is œdematous, it presents a curious semi-transparent appearance called *crystalline*. See Part IV., Chap. XXI.

7. Inflammation of either testicle, or of the ovary in women. See Part IV., Chap. XXI., also p. 201.

Besides these seven complications, which arise from an extension of the local inflammation, gonorrhœa has at least one well-marked secondary symptom, depending possibly on absorption of pus.

Gonorrhœal rheumatism; pain, swelling and tenderness of the joints, especially of the knees and ankles, and feverishness. This generally comes towards the decline of the complaint, and attacks young people of a delicate strumous habit. The same persons are also liable to rheumatic ophthalmia, or inflammation of the fibrous structures of the eye; but this must not be confounded with the gonorrhœal inflammation of the conjunctiva, which is caused by the contact of the discharge. Bacot says, that the rheumatism is sometimes suddenly relieved by the appearance of patches of minute papulæ or pustules.

Gonorrhœa is always most severe in first cases, and in patients who

are very young, or who possess irritable or scrofulous c
In such cases it may be attended with extreme fever and c
disturbance, and may even prove dangerous to life by leadi
sive abscesses in the neighbourhood of the bladder.*

But after repeated attacks, the urethra becomes, as it
to the disease, and each subsequent infection is generally (a
always) attended with fewer of the symptoms of acute in
In some instances the constitutional affection is extremely
and characterised by severe and continuous rigors.

Gonorrhœa sicca.—There is one form of gonorrhœa wh
sionally met with in the male, and Mr. Acton has often me
the female, in which the mucous membrane is red, swollen,
but the discharge scanty, flaky, or wanting. In the mal
severe scalding and pain in making water, with painfu
and the lips of the urethra are red and swelled. This forr
has the popular name of the *dry clap*.

CAUSES.—Suppurative inflammation of the urethra ma
by, 1. *Local irritation* of any sort, especially immoderat
tracted sexual indulgence, and the introduction of bougies.
of the constitution, gout, rheumatism, lithic and oxalic grav
charges are sometimes occasioned by the *use of particula*
as guaiacum and cayenne pepper. 4. By unhealthy secreti
chaste women.

Thus—(*a*) The *menstrual fluid* is capable of causing ure
violent scalding and chordee, and followed by swelled tes
considerable degree of irritation may be produced by the va
tions, just previous to menstruation.† (*b*) Similar c
sometimes ensue if the female be affected with any dischargi
or if connection occurs during the later stage of pregnancy.
that all purulent discharges are contagious. But the m
contagious poison is the pus proceeding from genital organs,
flamed by preceding contagion. This is the cause o
gonorrhœa virulenta. The inflammations of the urethra ha
perfect analogy with those of the conjunctiva.

DIAGNOSIS.—The diagnosis of the simple gonorrhœa, tha
charge not arising from sexual connection, or which a ma
from some accidental malady in a clean, chaste woman, is w
up by Mr. Bacot in these words:—"If a discharge come on
hours after connection, and if it have continued several d
inflammatory symptoms; if the patient has been liable t
charge after any excess of venery or of wine; in all such ca
bability is that the patient labours under some other disease
of the urethra, and that although the intercourse of the
have been the exciting cause, still there may be no imputa
cleanliness of the female."‡

The time at which the disease usually appears after conta

* For cases, *vide* Judd, op. cit., p. 70. † Judd, p. 24.
‡ Bacot, op. cit., p. 101.

fourth or fifth day. The later it appears the less severe it generally is; yet in some very mild cases, the discharge comes on immediately after connection.

GONORRHŒA IN THE FEMALE.—It is important to consider the precise seat of the disorder. 1. There may be *vulvitis*, inflammation of the mucous membrane of the *external parts* only, that is, of the labia, nymphæ, meatus urinarius, and parts adjoining, corresponding to *balanitis* in the male. The discharge is profuse, often fetid, the parts much swelled, perhaps aphthous and excoriated, and there is great pain in walking and in making water. The inguinal glands may enlarge, or there may be abscess in the labia. 2. The *vagina* may be affected likewise. 3. The canal of the cervix uteri may be implicated, with or without abrasion of the mucous membrane.

CAUSES.—Discharges from the female organs may be produced by many causes. 1. Thus discharges of the first sort just spoken of are by no means uncommon in girls or women of any age, and may be the result of want of cleanliness, of teething, of disordered condition of urine, or of any other form of constitutional disturbance. The surgeon should be well aware of this, as parents are apt to be very much alarmed, and to attribute such complaints to improper causes. 2. Discharge of clear viscid mucus from the vagina is not unfrequent in feeble women, the parts of generation being patulous and relaxed. 3. The canal of the cervix uteri is, as Dr. Tyler Smith has shown, the seat of the true leucorrhœa; a discharge of tenacious alkaline mucus, containing abundance of round corpuscles. This is very commonly caused by mental and other circumstances affecting the health in general, and the generative organs in particular.

DIAGNOSIS.—Are there any certain means of distinguishing the discharges caused by infection from those arising from intrinsic sources? First, as to symptoms, it may be alleged that a purulent discharge occurring suddenly, with inflammatory symptoms, and excessively obstinate, affecting the vagina as well as the external parts of generation, in a woman who is not a virgin, is most probably gonorrhœal. The non-venereal cases, so far as the author has seen, are not so obstinate, and do not involve such an extensive track. If the discharge comes solely from the external vulva, or solely from the canal of the cervix uteri, with or without excoriation or granular surface, it is probably not gonorrhœal. But, 2ndly, if it come from the vagina, the diagnosis must be chiefly a matter of inference. Discharges from the vagina are acid, and consist of abraded epithelium and pus. But no microscopical or chemical test, at present known, enables us to distinguish these arising from idiopathic causes in chaste women, from those arising from contagion.

PROPHYLACTIC TREATMENT.—The only prophylactic to be relied on is chastity;—next to this soap and water, followed by an alum wash. Women should use a weak alum wash with a good female syringe (*F.* 129); and fissures or excoriations of the penis should be treated with lunar caustic, and a bit of dry lint.

once in four hours with a soluti
eight ounces of distilled water (
times, desisting, however, sooner
bloody, which is the ordinary ef
injection of sulphate of zinc be s
till the discharge ceases. At the
good purge, and after it, three t
should avoid exercise, fermented
lants of every kind; he should
this regimen for a week or ten da
disappeared. The penis should be

The manner of injecting is of
of the lotion depends entirely on
diseased surface; and, as Dr. Gr
that gonorrhœa is limited to the
unfounded and mischievous. Th
glass syringe, with a long bulb
should introduce it for about an
having encircled the glans penis w
as to compress the urethra against
fluid from escaping, he should pu
forefinger, letting the fluid pass fr
should now be withdrawn, but th
and the fluid be retained for two
removing the finger and thumb, it
of the urethra. It is always wort
injection is properly used.

Instead of using an injection, r
the inflammatory stage has come
repeated attacks, may be cured by
daily.

Of the second stage.—Supposin

to the entire exclusion of fermented liquors, and the patient should drink soda water, barley water, linseed tea, gum water, and other mucilaginous fluids. The scalding will be relieved by combinations of alkalies and sedatives (F. 174), and by a hip-bath of the temperature of 96°; but the bath should not be *hot*, nor even warm, otherwise it will excite the circulation and bring on erections. Yet Mr. Milton recommends washing the penis with water hot enough to scald painfully. The bowels should be opened with castor-oil, and sleep be procured by opium, henbane, Dover's powder, and other anodynes; or F. 30, 63, &c., every night whilst there is much pain and chordee. As soon as the patient is free from fever, he should take copaiba or cubebs. Young, irritable people, however, with light complexions, can seldom take these medicines without suffering from sickness or diarrhœa, or sometimes even from fever and a rash; and every combination of aromatic and opiate that can be devised will not enable the stomach to tolerate them.

If the patient is very plethoric, and suffers greatly from pain and fever, and has a hard pulse and white tongue—and if there be great aching in the bladder or perinæum, protracted agony after micturition, tenderness in the abdomen, pain in the back, or other signs of irritation of the urinary organs—it may be right to apply leeches to the perinæum, and to administer opium freely; or a nightly dose of calomel and Dover's powder, or tartar emetic, F. 62;—but it is of no use to *lower* a patient who is not feverish.

It is decidedly not safe to use injections with young, delicate, irritable subjects during the acute stage, and most especially whilst there is any tenderness of the glands of the groin, or any aching in the spermatic cord or testicles; as they might easily produce swelled testicle, or great irritation of the neck of the bladder. It is best to refrain from them till the inflammatory symptoms are removed.

Treatment of Complications.—Painful erections and chordee may be relieved by a bag of cold water, and a combination of narcotics with antiphlogistics, F. 30, 31, 174, &c.; and if the chordee lasts long, a little mercurial ointment and extract of belladonna should be smeared on the part at bed-time. Hæmorrhage may be checked by cold and pressure on the urethra. Inflammation of the mucous glands of the urethra is to be treated by poultices. The swelling may be punctured if it obstructs the flow of urine, but not otherwise. Swelling of the glands in the groin may generally be removed by rest, and, if necessary, a few leeches.

Of the third stage.—As soon as the acute stage has subsided, the patient should use the injections of nitrate of silver, followed by zinc, in the same manner as was recommended for the first stage. If the discharge does not cease entirely, or if it comes back again, other injections, F. 135—139, may be tried; adapting their strength to the irritability of the part, and not permitting them to cause severe pain.

But a gleet is often a very tedious complaint, and requires a judicious and long-continued course of remedies that act on the uri-

nary organs, together with most temperate habits of livi
either alone or combined with astringents, F. 176, tinc
F. 13, 180; and cantharides, especially in combinatio
F. 179, are the most useful remedies. The bowels should
perly open, but saline purgatives should be avoided. I
wants to make water oftener than natural, and there
sensation in the urethra afterwards, and the urine depos
cloud, buchu and uva ursi (F. 181) will be advisable
useful to inject the urethra with cold water from an elasti
a day. If the urine is preternaturally acid, or alkaline,
tive organs deranged, the case should be treated as di
section on urinary deposits. If the health is materially
debauchery or malpractices, affusion of cold water on the
sea-bathing, blisters to the perinæum, bark and steel, goo
perfect chastity of body and mind are the necessary
other means fail, a smooth metallic bougie may be intr
other day, or the *porte caustique* of Lallemand may be in
the purpose of slightly touching the whole of the ca
nitrate of silver.

For *gonorrhœal rheumatism* the patient should be con
and have warm baths. The bowels should be well cleare
and then ammonia with lemon-juice, F. 58, every four o
and a dose of Dover's powder at bed-time. In the chronic
or 72 at bed-time; iodide of potassium, F. 94, sarsa
volatile tincture of guaiacum, sea air, tonics, and warm
the remedies.

TREATMENT OF GONORRHŒA IN WOMAN.—Durin
stage, rest in the recumbent posture, fomentations of decocti
heads and camomile flowers, frequent hip-baths, lubricati
or ung. plumbi diacet., and very frequent sponging with
tion of alum, or of acetate of lead, F. 117, 135, 136, a piece
in which should be inserted between the labia, with saline p
58, and anodynes, F 30, are the measures to be adopted un
and tenderness subside; afterwards injections of alum or
acetate of zinc should be used, and be continued for some
discharge has ceased. The patient should be supplied w
containing 60 grains of alum, or of sulphate of zinc; o
some heat and soreness, 30 grains of alum and 30 of ace
either of which may be dissolved in a quart of water,
applications in the course of the day, by means of an
syringe capable of injecting a continuous stream. The v
be previously washed out with water, whilst the patient s
hip-bath, which also should contain a dessert-spoonful
solution. *Terebinthinate medicines* (copaiba, &c.)
unless the discharge proceeds from the urethra or its
is supposed that these medicines produce their good effe
excreted with the urine, and so coming in contact with
surface. Hence it has been proposed to use injections of

it is said that they do good in both sexes. Abscesses or other complications, if they occur, must be treated on general principles. In any obstinate discharge, the cervix uteri should be examined through the speculum, and the interior of its canal be touched with solid nitrate of silver, if a copious muco-purulent discharge be seen to issue from it. Steel is of service in chronic cases. An effective but coarsish method which the writer has seen in the Hôpital de l'Ourcine is to open the vagina with a bivalve speculum, and shovel in about a dessert-spoonful of powdered alum.

Gonorrhœal ovaritis.—Gonorrhœa may be complicated with inflammation of the ovary, and it is said, even with pelvic cellulitis. The symptoms are severe pain deep in the pelvic region, aggravated by coughing, movement, and pressure; with feverishness and probably vomiting and great general disturbance. The practitioner will recognise an inflammatory attack; he will make out that it does not belong to the bowels or urinary organs; and he will probably gather from the patient the existence of heat and scalding, of swelling and tenderness, and purulent discharge. Then if the patient be a respectable married woman, as has been the case with patients whom the writer has seen, the gonorrhœal element must be a matter of speculation unless the husband confesses it. A few leeches, castor oil, warm fomentations and poultices, and soothing poppy injections are the remedies.

SECTION III.—OF THE SOFT, OR SUPPURATING VENEREAL SORE, OR CHANCROID.

General Description.—This is the most common form of venereal ulcer, and is rarely met with except on the organs of generation. In man it is most common on the inner surface of the prepuce or in the furrow round the glans, and especially by the frænum. It is most liable to attack some crack, or excoriation, or get into some sebaceous or hair follicle, or to be imbibed by moist mucous membrane; and is probably innocuous on dry cuticle. Hence the preservation derived from circumcision and uncovered glans. This ulcer has no period of incubation, and probably acts continuously from the moment when the poison first takes effect. It is often multiple; it is very contagious, and easily inoculable, spontaneously or by art, up to the time when it begins to heal.

Symptoms.—These may be studied when this sore is produced by inoculation with the point of a lancet. It corresponds to the type of an ulcer, p. 69. During the first twenty-four hours the puncture reddens; in the second and third days it swells slightly, and becomes a pimple, surrounded by a red areola; from the third to the fourth day, the cuticle is raised by a turbid fluid into a vesicle, which displays a black spot on its summit, consisting of the dried blood of the puncture; from the fourth to the fifth day, the morbid secretion increases and becomes purulent, and the vesicle becomes a pustule with a depressed

summit. At this period the areola, which had increased, begins to fade, but the subjacent tissues become infiltrated. After the sixth day, if the cuticle and the dried pus which adheres to it be removed, there is found an ulcer; its depth equal to the whole thickness of the true skin, its edges seeming as if cleanly cut out with a punch; its surface covered with a grayish pultaceous matter.*

The discharge is purulent; the sore is often painful; and attended with inflammatory swelling, which gradually fades into the sound tissues, and is not very hard unless caustic has been used. It is tedious, lasting from three weeks to three months, and occasionally attended with bubo; which doubtless arises from absorption of poisonous matter, and is sure to suppurate, and after suppuration to leave an ulcer with the characters of the original sore.

The great test, as M. Ricord showed, of the nature of this disease is, that the pus from the original sore, or from the *centre* of a suppurating bubo, if inoculated, produces an ulcer as already described. If this be done by way of diagnosis—a thing not to be advised—the sore should be destroyed by nitric acid, so soon as its nature is developed.

TREATMENT.—This ulcer is serious enough, although it does not lead to secondary symptoms. The first point is to insure rest in bed: then, if possible, to destroy the ulcer by concentrated nitric acid. The way is, to dry the ulcer with a bit of cotton wool, and immediately apply a bit of stick the size of a lucifer match, dipped into the acid, so as to destroy the surface, wiping off any excess. If, when the eschar falls, the ulcerative process seems inclined to return, the acid may be repeated. The most favourable conditions for cauterization are, if the ulcer be under six days old, uninflamed, and at the edge of the prepuce where it can easily be got at. Not so if the sore is of some duration, large, inflamed, and close to the orifice of the urethra. Such cases are left to time, and the application of mild antiseptic lotions on lint, F. 125, 131, 132. An ulcer should not be allowed to touch a sound surface. Rest, aperients, moderate diet, and anodynes, to allay irritation and erection at night, F. 30, 31, are essential.

SECTION IV.—INFLAMED SLOUGHING, PHAGEDÆNIC AND SERPIGINOUS VENEREAL SORES.

1. *Sloughing*, from *acute inflammation*, a true *inflammatory gangrene*, may affect the penis of persons who contract venereal sores, and are exposed to filth, intemperance, heat, and great local irritation, and especially if there be phymosis. There is immense swelling, sanious discharge, and sloughing of the skin where distended. The celebrated *Black Lion*, which affected the English troops in Portugal in the Peninsular war, was a sloughing of the penis from acute inflammation. Thus was it in a case related by Inspector-General Fergusson;† a young officer, four days after connection, penis enormously swelled and

* Ricord, op. cit., p. 89.

† Fergusson, Med. Chir. Trans. vol. iv., and Guthrie, vol. viii.

deep red; "malignant ugly chancres on prepuce and glans," looking like holes made by a rusty nail in a piece of mahogany; skin hot, pulse sharp, tongue white, eyes red, &c. Copious bleeding, cold lotions, and neutral salts as purgatives speedily reduced the tumefaction; in a few days the sores were in a state of healthy suppuration, and doubtless, says Fergusson, "would have healed safely without mercury had either the patient's fears or my responsibility permitted me to run the risk." This was clearly *chancroid*, plus local inflammation, and required no mercury. Syphilitic chancre has more than four days' incubation. In cases occurring to dirty and broken-down drunkards, and not to young robust men, it is usually the safest plan to slit up the prepuce; cleanse the inner surface with a syringe; apply poppy decoction, and weak astringent lotions; purge freely and give opium.

2. *Phagedæna.*—The chancroid is, as Mr. Acton observed, very nearly allied to phagedæna, but some sores present all the characters of phagedæna or sloughing phagedæna, mentioned at p. 76, spreading rapidly, painful, with profuse sanious discharge, and some diphtheritic exudation. This may depend on some acrimony in the discharge which produced the sore; or on the influence of filth, intemperance, &c.

3. *Serpiginous* sores are those which partake of the nature of *lupus non exedens*, wandering interminably over the surface of the abdomen or thigh, and healing in one direction whilst they spread in another. In all these atonic varieties of ulceration, opium must be given in doses large enough to allay pain, bark, mineral acids, steel, and liberal diet to support the strength. Ricord recommends the potassio-tartrate of iron in doses of gr. x. thrice daily. The local applications may be soothing, as F. 120–122; antiseptic, as F. 117, 127; astringent, as F. 128, 130, 131; or mercurial, as the black-wash, which certainly is one of the most healing applications possible:—but the calomel fumigation, *locally* applied, is probably the most efficacious remedy known for all indolent cachectic sores and eruptions whatever.

It has long been observed that locally destructive ulcers of the class we now treat of, are not necessarily followed by secondary symptoms, unless in the cases in which they are superadded to true chancre.

SECTION V.—CHANCRE.

General Description.—This, the starting-point of true syphilis, is usually much less formidable than the chancroid. Its most usual seat is the genitals, yet it may be met with on the lips, fingers, and elsewhere. There may be a considerable period of incubation after application of the poison, before the effects are produced, or discovered, usually fourteen, sometimes forty days.

Symptoms.—Chancre presents many varieties. There may be no ulcer at all; only a raised pimple, with some exfoliation of cuticle: or a mere excoriation, or fissure, or shallow smooth ulcer not perforating the whole thickness of the skin. The distinctive sign is an abruptly circumscribed induration, like that of a little bit of cartilage. Ulcer-

ation, or inflammation, or suppuration may accompany, but are accidental. The neighbouring chain of lymphatic glands enlarge and harden, but are not usually painful, nor tender, nor adherent. The discharge is, as Mr. Lee pointed out, not copious and purulent, but scanty, serous, containing epithelial debris instead of pus globules. This sore is most generally single. After it has acquired its characteristic induration, it seems to render the system invulnerable to infection from a fresh source. Hence it does not multiply, and cannot be inoculated on the same subject;—except, as Mr. Lee has shown, either before the characteristic hardness is produced, or else after it has been irritated and made to suppurate, when its secretion seems more actively contagious. It heals spontaneously in about six weeks or less; but does not heal absolutely. It is converted into a cartilaginous lump, prone to break out afresh, or sometimes into a wart or vegetation. Constitutional symptoms follow.

CAUSES.—The chancre is produced by infection from a syphilitic person, and of course is most common on the genitals, after impure connection. It is liable to occur on the fingers of the accoucheur or midwife who attends a syphilitic woman in labour. It may occur on the lips or tongue, from libidinous sexual practices, from kissing an infected person, or from drinking out of the same cup or spoon. Glass-blowers have conveyed it from one to another's lips. It may be communicated by foul linen, sheets, seats of privies, &c. It may arise on the nipples by infection from the mouth of a sucking child, and *vice versâ*; and probably on a child's nates from the hand of a nursemaid. It may also be communicated by inoculation, and especially by vaccination if the vaccine lymph be taken from a syphilized person.*

What is the poisonous agent?—1st. The secretion from a primary chancre. 2ndly. The secretion from any of the forms of secondary eruption or ulcer, mucous patch, &c. Tertiary symptoms are also inoculable. 3rdly. The blood of a syphilitic patient. Experiments on this point have been made, with negative results, by Diday, and others; but Waller and Pellizari have each proved the fact.† 4thly. "Not only are the secretions from secondary symptoms inoculable under certain circumstances, but the blood, and the *secretions of inflamed mucous surfaces in syphilitic patients, even where no distinct form of secondary disease is known to exist*, may be the means of communicating the disease."§ Hence a woman need not have a chancre herself, to cause one in a man; but any vitiated or unhealthy secretion, vaginal, uterine, &c., may do it; and so conversely may any urethral or other discharge from a syphilized man. 5thly. There can be no doubt but that the lymph of the vaccine vesicle may be the vehicle; and more especially if it have been irritated or made to bleed.

* For cases, see H. Lee, Lectures, pp. 188, 204, 260; see also the other writers quoted at pp. 193; 194 of this work.

† See Bumstead, p. 456, for a good *résumé* of this matter, and for one of the completest accounts of venereal diseases in general.

‡ See Bumstead on Venereal Diseases, Philadelphia, 1864, p. 465.

§ H. Lee, op. cit., p. 262.

e matter be not taken till the tenth day, when it becomes and puriform. An attempt has been made to prove that the cine lymph *per se*, without blood or pus, will only convey the disease and not syphilis. Surgeons, spite of facts, hang despe- o the skirts of their idol John Hunter, and strive to believe his that no two "actions" can go on in the same part at the same There seems to be no doubt, however, that vaccinia and syphilis implanted in the same puncture, and each follow its regular

The patient is both vaccinated and syphilized.* 6thly. The ntation of teeth, a thing begun in the last century, was put to by the fact that syphilis was sometimes transplanted as hus proving the infection of the whole solids and fluids of the

Lastly, syphilis may be communicated by generation. (See)

ATMENT.—Whilst the chancroid or soft sore should be destroyed tic, it is generally agreed now that such a proceeding is useless ommon infecting chancre. It is of no use whatever as a means enting secondary symptoms; for Langston Parker and Diday oroughly destroyed chancres within a very few hours of their earance, and yet an indurated cicatrix, and indolent enlarge- f the nearest lymphatics have come on and been succeeded ndary symptoms. Chancre generally heals of itself under l any simple astringent application, in three to six weeks; y the black wash, or calomel ointment, or, still more, the local fumigation. Then the local lesion ceases to be an open sore. e no doubt, also, but that a mercurial course in any case hastens the healing of primary sores. Whether it have the f averting secondary symptoms, we know not; but as it may nd as it satisfies the patient's mind, it is perhaps better to use there is any symptom of inflammation, spreading ulceration, or ena, it must be treated as the chancroid. (See Section III.)

VI.—DIAGNOSIS OF CHANCRE AND AFFECTIONS THAT MAY BE MISTAKEN FOR IT.

urgeon will perpetually be consulted by men who come in great show some breach of surface, after impure connection. If he that true chancre may infect any such spot; and that it may t for three, four, or six weeks; and that no destruction of an spot will save the constitution, he will take care not to pro- his patient safe too hastily. He will recollect, also, that chancre the smallest hard discoloured spot, crack, fissure, &c., any-

the most masterly *résumé* of modern syphilography, especially in rela- vaccination, see two papers in Med. Times and Gazette, 1862, vol. i. nd 268, ascribed to Dr. E. Ballard. See also a short account by the f a case which he observed at the Lariboisière Hospital in Paris, in er 1863, with coloured drawings of the vaccino-syphilized arms, in the Trans., vol. v. p. 196.

where; and he will look to the nearest lymphatics—above the elbow if the finger be infected, below the jaw if the lip.*

The following are the local affections which the patient is most likely to mistake for venereal sores. It must be remembered that he may have any of them and a venereal sore or sores besides.

1. *Gonorrhœa externa*, or *balanitis*, is an inflammation of the surface of the glans and inside of the prepuce, with profuse purulent discharge, and excoriation. It generally affects dirty people with long prepuce, and is caused either by the acrid secretions of the part, or by contact with unhealthy secretions in the female. Sometimes, however, it occurs to healthy people whose health is disordered. The thick, profuse discharge, the peculiar smell, the superficiality of the excoriations, distinguish this complaint from chancre and chancroid. The surface should be well washed, then dabbed with an astringent lotion, then be covered with bismuth powder or dry cotton wool. A purgative should be given. Lime-water is the best lotion if there is much inflammation, and a grain of corrosive sublimate to an ounce and a half of lime-water if there is not. If the cure is not effected in two or three days, the excoriations should be touched with nitrate of silver. Sometimes balanitis is attended with great inflammation and fever, and with *phymosis*, from the great swelling of the prepuce; and the pain may be so severe and gnawing, as to make the surgeon uncertain whether there is not a phagedænic ulcer concealed by the foreskin. The thick discharge, and the pain being general and not confined to one spot, form the chief means of diagnosis; and repeated injection of warm water and astringent lotions under the foreskin are the remedies.

2. *Minute aphthous-looking points*, sometimes in clusters, sometimes surrounding the glans; some of them healing, whilst others break out. They are totally devoid of pain; and although they may last a long time, do not lead to ulcers. They are best treated by black wash or mere lime-water, or lotions of arg. nit. or cupr. sulph. and alteratives and aperients.

3. *Herpes præputialis*† begins with extreme itching and sense of heat. The patient examining the part, finds one or two red patches, about the size of a split pea. On each patch are clustered *five or six minute vesicles*, which, being extremely transparent, appear of the same red colour as the patch on which they are situated. In twenty-four or thirty hours the vesicles become larger, milky, and opaque; and on the third day they are confluent and almost pustular. If the eruption is seated on the inner surface of the prepuce, the vessels commonly break on the fourth or fifth day, and form a slight ulcer with a white

* In the words of Ambrose Paré, "Quand le malade a quelque vlcer malin aux parties hauteuses, calleux, dur, et difficile; et encore quand les vlceres soient consolidés, et qu'il y reste certaine dureté" . . . "tumeurs aux aines, qui s'en returnant dedans le corps, sans de suppurer,"—*Œuvres d'Ambroise Paré*, par Malgaigne. Vol. ii. Paris, 1840. The English have characteristically claimed for Hunter the credit of pointing out the hardness which had long before been observed by others.

† Bateman on Cutaneous Diseases, 5th ed. p. 238; Burgess's Cazenave, p. 88.

base and rather elevated edges. If this ulcer be irritated by caustic or otherwise, its base may become hard like that of a chancre. If left to itself, it mostly heals in a fortnight; sooner, if situated on the external skin. The cause of this complaint is either some derangement of the digestive organs, or irritation within the urethra, produced by unhealthy urine. It is very liable to recur in the same individual, which, of course, if known, will greatly aid the diagnosis.

Treatment.—A little dry lint, or goldbeater's skin, at first, and subsequently a very weak lotion, with aperient and alterative medicines.

4. *Fissures praputii*, painful, irritable, and bleeding cracks or fissures around the edge of the prepuce; best treated by ung. hydr. nitr. dil., and arsenic internally.

5. Cracks, tears, injuries from a *hair*, and abrasions, should all be healed up as quickly as possible. Any of them may be the vehicle of chancre or chancroid.

SECTION VII.—BUBO.

DEFINITION.—Inflammation of a lymphatic vessel or gland, usually in the groin, and leading from a venereal sore.

CAUSES.—1. Inflammation of these glands is of the commonest occurrence, either after local application of a poison capable of being absorbed, or after an unhealthy inflammation of skin or mucous membrane, as erysipelas, eczema, &c., or, without any special local cause during a period of constitutional cachexia, as the scrofulous or syphilitic. Thus during gonorrhœa, or after immoderate sexual indulgence, intemperance, &c., there may be acute suppurating bubo, without the trace of any chancre or chancroid. Again, bubo coming during the existence of a venereal sore may be due, not to it, but to caustic, or some other superadded source of irritation. 2. Bubo may arise during the existence of chancroid, from absorption of its venom, and will almost certainly suppurate quickly. 3. Bubo depending on true chancre is usually multiple and indolent, "affording the sensation of one or more small circumscribed oval or almond-shaped bodies, perfectly distinct from each other, and unaccompanied by any redness of the skin which moves freely over the surface."* This bubo may be afterwards complicated with secondary infiltration of the skin over it, which may swell, and form an abscess or ulcerate, owing to filth, fatigue, abused mercurial frictions, or other source of local irritation; and thus may be the seat of phagedænic or other troublesome ulcerations.

SYMPTOMS.—*Bubo of the penis.*—A lymphatic vessel may inflame on the penis, feeling like a quill under the skin, and soon forming an abscess and open chancroid sore. 2. *Acute bubo* pursues the course of acute abscess. There is shivering, pain, tenderness and swelling of usually one gland; the skin becomes red, and *points*, and matter is discharged. If this bubo be the result of ordinary irritation it may rapidly get well. But in addition to the common suppuration, which in such cases takes place between the gland and the skin, there may

* H. Lee, Lecture Assoc. Journal, Jan. 6, 1854.

be a small abscess *within* the gland, which is caused by absorption from a chancroid, yields inoculable matter, and when let loose converts the whole abscess into a chancroid sore, with ragged elevated edges, foul cavity, &c. 3. *Indolent bubo.*—This occurs in persons, weak, scrofulous, or worn out, and may accompany any kind of sore or surface derangement, or may come from constitutional causes only. Glands enlarge; the tissue between them and the skin is slowly infiltrated; imperfect suppuration takes place at various points, undermining the skin, which perishes by slow ulceration.

It must be recollected that a venereal sore may be complicated with a glandular swelling *below Poupart's ligament*, arising from irritation about the foot.

Bubon d'emblée.—This is the name given by the French to a bubo, supposed to arise from absorption of virus from the skin, without ulcer or breach of surface. It is a point surrounded with difficulties, which wants years of close observation to make out.

It will be recollected that although suppurating bubo does not usually accompany the primary syphilitic sore, yet that it is liable to happen from general causes, to syphilized patients, and cannot be taken as evidence against the existence of constitutional syphilis.

TREATMENT.—Acute bubo must be treated as an acute abscess; by rest in bed, aperients, hot fomentations, or an ice bag—whichever the patient finds most agreeable; soothing applications to the original sore; and perhaps a few leeches. If these measures diminish the acute symptoms, without dispersing the tumour entirely, it will be well to try irritation of the surface by iodine paint; pressure by means of a pad and bandage; or by a weight applied as the patient lies in bed; and combinations of tonics with aperients, F. 41.

If, spite of these measures, the skin becomes thin and shining, the matter should be let out by a sufficiently free incision. Then after a day or two, lint dipped in solution of nitrate of silver may be passed down to the bottom of the wound with a probe. The indolent bubo, when followed by infiltration and threatening abscess, may also be treated with tonics and aperients, steel, cod-liver oil, and good diet; and iodine paint, or a small blister may be applied. Should matter form and the skin become thin, an incision should be made.

There are three sources of difficulty in treating the later stages of bubo. One is loose thin bluish skin undermined with sinuses. This may be dealt with by laying open the sinuses, and destroying red ulcerating flaps of skin with caustic potassa, or the strong iodine paint. Secondly, indolent glands left at the bottom of sinuses, or projecting into the midst of the sore, denuded of skin, and incapable of granulating. These may be attacked with solid nitrate of silver, or a grain or two of red precipitate be sprinkled on them; some surgeons detach them with knife or scissors, or the finger nails. Thirdly, the supervention of phagedænic or serpiginous ulceration, which requires change of air, opiates at night, bark or steel, good diet, &c.; and the local remedies we have before pointed out (pp. 71, 203).

SECTION VIII.—CONSTITUTIONAL SYPHILIS.

That which really distinguishes the true chancre above other primary venereal ulcers is that it is the forerunner of that frightful *lues* or *pox* whose ravages date, as far as we know, from the siege of Naples. The multiplicity of diseases it may create is astonishing; but they generally appear in a certain order as to the parts attacked, and as to the nature of the lesion. First, the skin and mucous membranes; then the iris, the tendons, aponeuroses, and periosteum; lastly, the viscera, testicles, brain, and liver. At first the lesions are blotches or pimples, or scurfy desquamations; the later ones are purulent suppurating ulcers of the skin or caries of the bones. The original chancre is usually called the *primary*—the first in time and severity of the constitutional symptoms, the *secondary*—and the latest and worst, especially the foul ulcers, the *tertiary*. But the clearest division is that proposed by Dr. Wilks.* The induration and glandular enlargement which occur at the original site of infection, together with all the characteristic syphilitic affections of structures, external or internal, should be called plainly 'syphilitic'—thus including both the primary and secondary. Whilst the *tertiary* should be called *sequelæ* of syphilis, inasmuch as they consist, not of syphilitic disease pure and simple, but of various cachectic conditions, foul ulceration, caries of bones, &c., which are not peculiar to syphilis, though they may be induced by it, as they may also by scrofula or other cachectic conditions.

The *peculiar effect of syphilis* on the system, says Dr. Wilks, "is a disposition to the effusion of a low form of lymph or fibro-plastic material in nearly every tissue of the body. In those who have died suffering from this disease, there is scarcely an organ but what may be found affected in this particular way." The lymph may form the hard base of chancre, tubercles and mucous tubercles of skin, the hard base of ulcers, nodes on the bones, *gummata* on tendons or in the areolar tissue, fibroid nodules in the liver and other internal organs. The exudation is soft at first, denser afterwards; may be absorbed in fortunate cases under good treatment; or may remain as shrunken hard nodules to the end of life; or may soften and undergo ulceration. No special structure has been found in it, only *fibro-plastic* elements.

The first outbreak usually occurs at about six weeks. It may be earlier, or may be postponed for some months—rarely more than six. The later attacks may go on at intervals for thirty or forty years if the patient live so long. Whilst the system is syphilized, it is difficult or impossible for the patient to acquire a fresh primary chancre. Yet cases have been collected by Diday, Bassereau, and others of second chancre, which fact is evidence that the syphilitic diathesis had been entirely cured.

* Guy's Hospital Rep., Third Series, vol. ix., On Syphilis of Internal Organs.

symptoms, is remarkable.

Relapses.—After the first outbreak has disappeared, there to be a relapse and a fresh set of symptoms; perhaps iritis, the bones, scaly patches on the hands and feet, headaches, and pains in the bones.

Later symptoms.—If the disease go on, it begets a tendency *degeneration* in various organs—that is, to the infiltration of structureless, thickening matter, in spleen, liver, kidneys, the primary deposits in skin or areolar tissue or bone like cancer, and soften down into foul ulcers. The wri after entering practice, attended the wife of a tradesman, a eighteen, just married, and of perfectly good character, for syphilis. The husband denied all knowledge of the cau was treated for a very short time; brought forth a dead chi year after, another, who exhibited signs of syphilis, and wa with mercury. This boy's teeth are depicted at p. 221. H about twenty-four: has repeatedly been in hospitals for iritis, rheumatism with valvular deposit. During one rheumatic which the writer saw him, his skin exhibited a mottled rash, syphilitic roseola. The father went on without treatment, apparently perfect health, for at least fourteen years, then suffe enlarged liver and dropsy. But about twenty-one years original attack he again came in a dying state under the auth He then had foul, shallow, suppurating patches on the thighs a arms (*ecthyma*); fistula lachrymalis on the left side, with enl and suppuration of adjoining bone; alæ nasi thickened, and ea at the edges; bridge of nose sunk, with fetid discharge; voice whisper, from ulceration of larynx, with copious muco-purule toration; vomiting after almost any kind of food; he lived o which he craved for and took in large quantities; liver gr larged; some ascites; one testicle enlarged and hard as a sma nut; diarrhœa and tenesmus; and the most foul look and sm

I. Of the Skin.—*Loss of hair* from the scalp, eyebrows, and lids, is very common as an early, and transformation of the nails into scaly masses, with perhaps deep ulceration round their root, as a late symptom.

Syphilitic Eruptions vary in degree from the slightest discolouration to the most inveterate ulcers. 1. In the mildest form, the skin is mottled and stained in irregular patches of a brownish-red colour, which are caused by a slight swelling and vascular injection. A greater degree of the same derangement will produce *syphilitic psoriasis*, in which the skin is raised in copper-coloured blotches, covered with scales of hypertrophied cuticle. Or there may be an eruption of *papulæ* or pimples, varying in size from a pin's head to a pea, or an *eczematous* state; surface red, shiny, and oozing. These eruptions are succeeded merely by scabs or exfoliations of the cuticle. Or there may be a copper-coloured mottling of the skin around the abundant pimples of acne on the back, breast, and shoulders.

2. *Scaly Eruption* (*Lepra syphilitica*) is an aggravated variety of the preceding. It begins with an eruption of copper-coloured blotches, which become covered with scales of enlarged cuticle; these are succeeded by scabs, and, when they fall off, by shallow ulcers with copper-coloured edges.

3. *Vesicular Eruption* (*Rupia*). Large flattened bullæ, filled with serum, which gradually become purulent, and finally dry into scabs, under which the skin is ulcerated. The ulcers spread under the scabs, and the latter become remarkably thick from successive additions, so as to resemble oyster, or limpet shells.

4. *Pustular Eruption* (*Ecthyma*). Large pustules, prominent or flat, with a copper-coloured base, leading to ulcers.

5. *Tubercular Eruption.* Broad, red, copper-coloured tubercles, forming most frequently at the alæ of the nose, or on the cheeks. They gradually suppurate, and are succeeded by deep irregular ulcers, terminating in puckered cicatrices, and belong to the class of cachectic affections.

II. Of Mucous Membrane.—*Mucous Tubercles* (*Tubercle Muqueux, Pustule Plat, Condyloma*) consist of thickened patches of skin,

* This cut exhibits the crusts of rupia. From a cast in the King's College Museum.

with a red and moist surface like that of mucous membrane, exuding thin acrid and ill-smelling discharge. The most frequent situation the neighbourhood of the genitals, or any other place where t surfaces of skin are in contact. They seem to consist of patches psoriasis, modified by the moisture of the situation. (See p. 69.) Th are most common about the anus and scrotum; and especially the vul and perinæum in women, on the lips a nostrils, and between the toes (*rhagades*). They are eminently co tagious to the patient and others, and often accompanied with war growths, by which the genital organs of common prostitutes are co verted into huge stinking masses of thickened tissue.

Syphilitic Sore Throat.—1. Next to the mucous patch, t mildest variety is a superficial excoriation of the mucous membrane the tonsils or some other part of the mouth or fauces. The pa affected are swollen and sore, usually red and glazed, and stripped the natural epithelium: this state may exist in a mere patch, or m extend over the tongue, and inside of the lips. When attended wi patches of thickened copper-coloured and vascular skin, and redn of the conjunctiva, and soreness of the nostrils and ears, it has a ve characteristic appearance.

2. The *excavated* ulcer looks as if a piece had been scooped out the tonsil. Its surface is foul and yellow, its edges raised, and ragg and swelled. There is remarkably little inconvenience from it, a very little constitutional affection, unless it be attended with erupt likewise. The patient has a peculiar guttural way of speaking, a often complains of pain in the ears.

3. The *sloughing* ulcer begins as a small *aphthous* spot, which rapid ulcerates, and is attended with great pain and fever. The surface the ulcer is covered with an ashy slough, and the surrounding muc membrane is dark, livid, and swollen. The lingual artery may opened by the spread of the ulceration, and the patient may die hæmorrhage, unless the common carotid is tied. A complication tertiary syphilis in a broken-down system.

III. Syphilitic Ulcerations of the nose and palate comme with excoriations and mucous patches, which in cachectic persons m be followed by ulcerations of the mucous membrane, similar to th of the throat, which may denude the periosteum, and then prod exfoliation of the bones, with profuse fetid discharge and odious formity. Ulceration of the nose generally begins with a sense of h and dryness, and snuffling.

Syphilitic ulceration of the larynx is characterised by tenderness, g huskiness of voice (which frequently degenerates into a mere whisp suffocative cough, and expectoration of bloody purulent matter; th is great loss of flesh and strength, and life is often terminated by focation from contraction of the ulcers when cicatrizing.

IV. Syphilitic Disease of Periosteum and Bone most quently attacks the tibia, ulna, os frontis, clavicle, and other superfi bones. It commences with tenderness of the affected bone, and se

pain, which begins in the evening, and lasts almost all night, but ceases in the daytime. The pain is shortly accompanied with oblong swellings, called *nodes*, arising from infiltration of the periosteum with

lymph and serum. These swellings are rather tender; they communicate a doughy feeling, or obscure sense of fluctuation to the fingers, and the skin over them is at first pale and moveable. If the disease be arrested at this stage, it causes merely a superficial deposit of rough porous bone (syphilitic exostosis); or else a consolidation of the bone itself through the deposition of fresh osseous matter into its cancelli. If the disease proceed one step further, a quantity of glairy serum is effused between the periosteum and bone, producing an exquisitely-painful fluctuating tumour. If it advance still further, the bone may become carious; matter form between it and the periosteum; extensive exfoliations ensue; the patient suffers severely from the pain and discharge; and if the disease be seated on the head, death may ensue from irritation of the dura mater, or protrusion of the brain through apertures in the skull. Such aggravated cases are fortunately now very rare.

V. Of Muscle and Tendon.—Tumours called *gummata*, and

* This cut shows the ravages of syphilitic caries. From the King's College Museum.

consisting of lymphy exudation, may form in the areolar tissue, on tendons, or in muscle. They are affected with severe nocturnal pain. A patch of this kind of unhealthy inflammation is apt to form on the tongue, and after a time if a cachectic state be induced, it softens down and an abscess breaks, disclosing a ragged excavation, filled with orange-coloured sloughs, and exuding a copious fetid discharge. If it occurs on the palate, a probe will detect bare exfoliated bone; which rapidly perishes and leaves a hideous chasm.

VI. OF INTERNAL ORGANS.—Syphilitic phthisis from fibroid deposit in the lung; the same state of liver and spleen with ascites, dyspepsia, &c., are diseases for which we must refer the reader to Wilks and Marston.

VII. OF THE NERVOUS SYSTEM.—Paralysis, especially if dependent on disease of the spinal cord, or of some single nerve, and fits of epilepsy, coming on without due cause in a young adult, should always lead to inquiry for syphilitic contagion.

The writer cannot help urging on his medical brethren the duty of making this inquiry in cases of inexplicable organic disease. Some time since he treated a healthy young man, who with slight syphilitic rash had violent hæmoptysis. This passed off, leaving the lungs healthy. Some months afterwards came anæmia, enlarged liver, and a peculiar straw tint of skin, with great tenderness and pain in the epigastrium. During this attack, the urine was several times of the darkest porter colour, from dissolved hæmatine. The patient seemed at death's door, but was treated on the hypothesis that the malady was syphilitic, and recovered under iodide of potassium and sarsaparilla.

For Syphilitic Disease of the Eye, Testis, &c., see Part IV.

SECTION IX.—TREATMENT OF CONSTITUTIONAL SYPHILIS, ESPECIALLY BY MERCURY.

Modern experience has shown that syphilis, primary or secondary, may get well of itself. This is most likely to happen to robust persons who lead regular lives, take out-door exercise, and perspire freely. It has also confirmed the universal testimony of mankind to the efficacy of mercury in removing existing syphilitic symptoms. But, as Dr. Wilks has well pointed out, the universal experience of mankind shows mercury to possess a certain liquefacient or deobstruent virtue through which it probably tends to remove that caco-plastic deposit which is the characteristic of constitutional syphilis. But unluckily it does not stop there,* for it tends to produce anæmia, nervousness, and cachexy by its accumulation in the system, and severe and depressing diarrhœa and tenesmus if it makes its way out by the bowels. The problem for the practitioner is to secure the first, and avoid the second effect; for mercury, as Dr. Wilks observes, is a foe to syphilis, but a friend to those ulcerative and suppurative cachexies which con-

* See the remarks on Mercury by the late venerable Dr. Farre, quoted in R. Ferguson on Puerperal Fever.

e syphilitic patient should be careful to protect his skin from
d should therefore dress warmly. He should live well, avoiding
atibles and things likely to disorder the bowels. His hours
e early. If there be any indication of anæmia, or debility,
k, or quinine, or cod-liver oil should be freely given: with
porter. Pain should be allayed by opium, and the air be

n the object is, if the practitioner determine to give mercury,
, *gently*, mercurial action, and to keep it up *long enough*.
e are three modes of effecting this: fumigation, friction, and
dministration.

ation is the oldest mode of applying mercurial vapour whether
disease, primary or secondary, or to impregnate the whole
For the most part, however, it was a difficult and very
operation, till Mr. Langston Parker* revived and improved
bining the vapour of water with that of mercury; but the
mprovement is that effected by Mr. Henry Lee, who has
alomel as the preparation to be employed, instead of the sul-
oxide which had been used previously, and which required
d in very much larger quantity, and could not be depended
their liability to undergo decomposition. Instead of one or
chms of oxide or sulphuret, Mr. Lee prescribes ten grains
l for each fumigation. Of course rather more or rather
be used at discretion. If the patient can afford it, he may
instrument maker's an apparatus consisting of a lamp so
as to evaporate both the calomel and some water, with an
er cloak to confine the vapour. A poor man must content
ith a heated brick or tile, which may be put into a chamber-
a cane-bottomed chair, on which he will sit *in puris natu-*
aving a blanket round his neck, enveloping the chair and
nd retaining the vapours. The heat of the lamp or brick
such as to evaporate the dose of calomel evenly during the
teen minutes which should be spent in the operation; not
te it too soon.

ness of cicatrix and glands, or the secondary symptoms have
or are vanishing;—or, in other words, so long as the sy
general or local, continue. Generally speaking, three to fou
weeks is long enough. See *erethismus*, p. 217.

If the internal administration be preferred, five grains of
should be given every night and morning, and if no effect on th
is produced by the sixth day, the dose at night should be doub

Calomel in dose of a grain night and morning, with half a
opium takes effect very quickly. The prot.-iodide in dose of
at bed-time, or gr. ¼ four times a day, is the favourite re
Ricord.

The *strong mercurial ointment* is not so likely to disorder th
as the blue pill, but it is more troublesome, and is now almost
lete remedy. The dose is from ʒss.—ʒj.; to be rubbed in da
the inside of the thighs or arms till it disappears. The morni
best time for doing it, as the skin is then softer. It should b
on different limbs successively, the patient wearing the same
both by day and night. If the skin becomes irritated, it shoul
washed and bathed. If the patient cannot rub in the ointm
self, it must be performed by a servant whose hands shoul
tected by a pig's bladder, well softened in oil and tied round h

THE ILL EFFECTS OF MERCURY depend, first, on its ten
localize itself, or to seek peculiar outlets for elimination; and,
on its tendency to destroy or impoverish the blood constituent

To the former category belong: 1. *Irritation of the bow*
dysenteric symptoms, straining and tenesmus. To be treated
with chalk mixture; hip-bath, and opiate enema, F. 101; omi
mercury for a few days, and combining it afterwards with opi
using double precaution against cold and damp.

2. *Sore throat.*—Redness of the whole fauces, and ulcerati
tonsils with fever. In this case the mercury must be discont
the present.

3. *Violent salivation.*—This may be caused by a too liber
the remedy, or by a sudden check to the cutaneous secretion by
damp, or by loss of blood, or anything that suddenly lowers th
It is, however, very common to meet with persons who are
by very small quantities; and every practitioner should make
of ascertaining this before he prescribes mercury for any new
There is good reason for believing that a great susceptibility
tion and tendency to Bright's disease of the kidney often go
The *symptoms* of severe salivation are, swelling and inflamm
the salivary glands, cheeks, tongue, and fauces, with a flow
liarly fetid saliva, and superficial sloughing of the surface of t
and of the inside of the cheeks. The best *local applications*
state are, gargles of brandy and water, of the solution of ch
lime, of tannin, or of hydrochloric acid (F. 107, *et seq.*), or ch
potass (F. 204). The bowels should be kept open by aperients; w
patient should have a good diet, and the iodide of potassium w

may be given. The experiments of M. Melsens, showing the fact that mercury and other metallic substances may long continue in the body in combination with the tissues, and that they may be dissolved out and eliminated through the kidneys by means of the iodide of potassium, furnish a good explanation of the *modus operandi* of this medicine, in all cases in which mercury has been administered to excess.* Change of air, and especially removal from the venereal wards of an hospital, are indispensable.†

4. *Eczema mercuriale* (*Eczema rubrum*, *Erythema mercuriale*, *hydrargyria*), a disease now unknown and depending on abuse of mercurial frictions, consists of patches of redness and inflammation, which appear first on the groins, axillæ, and flexures of the limbs, and then spread over the trunk. These patches are covered with minute vesicles, which soon burst, discharging a thin acrimonious fluid, and leaving the surface excoriated, and exceedingly painful and tender. The discharge often becomes profuse and fetid, and the affected parts much swollen and fissured. It generally lasts for ten days, but may remain for many weeks.‡ *Treatment.*—Warm bathing; fomentations of decoction of poppies, camomiles, or bran; aperients, diaphoretics, and opiates, during the early stages; subsequently, bark or sarsaparilla, and the mineral acids. Dr. Colles has described another and less severe form of eruption, which resembles the itch, except that the intervals between the fingers are free from it. The treatment is the same.

5. *Erethismus mercurialis* consists in an impoverished state of blood, and want of nourishment of the heart and brain. The symptoms are great depression; anxiety about the præcordia, dyspnœa, frequent sighing, weak and tumultuous action of the heart;—frequent sense of suffocation, disturbed sleep, and faintness upon any exertion, which faintness might prove fatal. In a case which the writer lately treated, calomel fumigation had been continued for eleven weeks, in order to get rid of an indurated cicatrix, and to prevent secondary symptoms; one of which, the cicatrix continued indurated, and psoriasis had appeared when the writer saw the patient, a fortnight after the discontinuance of the mercury. The symptoms were anæmia, intense debility, sleeplessness, night sweats, copious urine, great nervousness, palpitations on the slightest exertion, and entire impotence. This case shows that the calomel fumigation is capable of doing as much mischief as mercury in any other form, and that it is unwise to push mercury as a *preventive* of future symptoms. If used judiciously it will relieve such manifestations of syphilis as exist, but cannot always be expected to eradicate the diathesis at once. *Treatment.*—Removal to a fresh atmosphere; stimulants; tonics; and nourishment; espe-

* See Dr. W. Budd's Translation of the Essay of M. Melsens, in the Brit. and For. Med. Chir. Rev., Jan. 1853.

† Dr. Macleod relates two cases of coma following the sudden cessation of salivation; one fatal; the other cured by reproducing it. Lond. Med. and Phys. Jour. vol. lvi. p. 231.

‡ One variety, *Hydrargyria maligna*, now almost unknown, is attended with typhoid-like fever. Eight out of fourteen cases died. Alley on Hydrargyria, Lond. 1810.

cially decoction of bark with nitric acid; followed by small doses of iodide of potassium.*

In whatever way mercury be administered, many practitioners always give iron or quinine, or both, at the same time; and after it, a course of iodide of potassium with some bitter, F. 1, 4, 13, 17, 19, 94, 205.

In the case of secondary symptoms, if they are ushered in with pain in the chest and febrile symptoms, it will be necessary to give saline medicines and warm baths, and confine the patient to the house.

When the febrile state has vanished, if the patient has never taken a course of mercury,—or if he has been subjected to an imperfect course of it for the primary symptoms,—and his constitution is sound, he may take a course of calomel fumigation. If, under its use, the strength and general appearance are improved, so much the better; but if he gets thinner, weaker, and haggard, and suffers from chills or feverishness, or if his ulcers become irritable and phagedænic, it must be given up, and the iodide of potassium be substituted.

In the later stages of secondary and tertiary syphilis, mercury must be used with great caution, more especially if the lesions incline to ulcerate and suppurate. Yet in such cases the bichloride combined with bark or steel, F. 87, Plummer's pill, F. 66, and the biniodide with iron are of most service.

The iodide of potassium is especially useful in the later stages, and in all cases of syphilitic deposit or eruption, in which mercury is judged inexpedient, or has been given so far as is thought prudent, without relieving the symptoms. It is best to give it for two or three weeks, then change it for some other tonic and alterative. The strong decoction of sarsaparilla has the deserved reputation of healing irritable ulcers, and adding to the patient's nutrition. The muriate and carbonate of ammonia are often combined with the iodide of potassium, F. 197. The sudorific decoctions of guaiacum, drank hot in large quantities, are perhaps not so worthless as they have been deemed. The chloride of gold in doses of gr. $\frac{1}{12}$, seems sometimes to do good. The surgeon will need great variety of remedies, in protracted tertiary cases. The main object should be to improve the general look and condition of the patient; to treat symptoms; to give short courses of alteratives in succession, continuing each so long as it does good; never to push a remedy, if it does manifest harm, under the vague idea that it is specific; and to try and wear out the disease with as little harm to the constitution as possible.

Local Treatment.—For syphilitic eruptions, the warm, vapour, and sulphur baths will be often expedient. Obstinate patches of lepra or pimples may sometimes have their removal hastened by ung. hydr. nitratis diluted, or the ung. hydr. precipitati albi, or the ung. picis. Itching eruptions may often be relieved by a weak lotion of corrosive sublimate. Ulcers must be treated according to their condition, whether inflamed, irritable, or indolent. In general, weak mercurial applications, such as black wash, or weak red precipitate ointment,

* Vide Dr. Bateman's case, Med. Chir. Trans. vol. ix.; Colles' Lectures on Surgery, vol. ii. 242.

answer best as local applications, without reference to any constitutional effect.

For the loss of hair, a pomade containing a very small proportion of ung. hyd. nitr. scented;—and the roots of the hair should be well cleansed by rubbing with a bit of soft flannel dipped into vinegar.

For the common excoriated sore throat, any soothing detergent gargle will do—F. 107, 108. When there are ulcers, it is advisable to use gargles of corrosive sublimate (F. 112); and when the ulcers are indolent they may be touched with the *linimentum æruginis*. *Mercurial fumigation* may be used to the part affected. When a foul ulcer is seated on the velum, or roof of the mouth, or pharynx, or alæ nasi, an attempt may be made to check its ravages, by destroying its surface and edges with nitric acid. Ulceration of the larynx is occasionally benefited by similar fumigation, but mercury so as to affect the mouth is almost always injurious; as it is in other cases of rapid ulceration. Sarsaparilla and sedatives, blisters to the throat, and occasional leechings, swabbing with solution of arg. nit., and the operation of tracheotomy, if the breathing becomes much embarrassed, are the necessary measures. Mucous tubercles about the genitals should be washed with solution of chloride of soda, and then be sprinkled with dry calomel.

The pain of nodes is often relieved by blisters, and so are rheumatic pains of venereal origin. Acute inflammation of the periosteum or pericranium is best treated by iodide of potassium, in doses of three grains every four hours, and Dover's powder; the use of mercury requires the greatest caution, and is only admissible if the patient has a sound constitution, and has never taken a course of it. It is peculiarly noxious when there is caries of the bones of the nose. When nodes are very tense and full of fluid, it may be necessary to puncture them, but it is better to adopt Mr. W. Fergusson's plan of subcutaneous incision, instead of direct puncture. If during secondary syphilis, the nose becomes tender or painful, the greatest benefit will be derived from the application of one or two leeches twice or three times a week to the inside of the affected nostril. At the same time the patient should take plenty of sarsaparilla, with iodide of potassium, and should have the benefit of country air, and a nutritious diet. By these means, any further mischief will sometimes be averted. If, however, ulceration does occur, it is of the utmost consequence to remove any loose or carious portions of bone as soon as possible.

The practitioner who treats obstinate tertiary symptoms has need of some knowledge of cookery. We particularly commend various soups, taken as medicines in large quantities: their effects are soon evident on the skin and kidneys. Whey; diet drinks with hartshorn shavings; isinglass, &c.; sweet wort, good stout; &c. (F. 85, 196, &c.) Lastly, whenever a case is doing badly, and irritable inflammation or ulceration spreading, in defiance of ordinary remedies, the surgeon should cinchonize the patient; that is, give five grains of quinine every four hours till the ears ring, F. 3.

This book is the p

SECTION X.—CONGENITAL SYPHILIS.

THE FŒTUS IN UTERO and the membranes of the ovum are often infected with syphilitic disease. As regards the precise *cause*, it seems agreed that a syphilized father or mother—whether the infection be new or of long standing—may beget a syphilized fœtus. It is certain that if a woman be infected at any period of pregnancy she may give birth to a syphilized child. It is also believed that the father may beget a syphilized fœtus, whilst the mother shall remain intact, or only be infected secondarily by imbibing the secretions of the syphilized child; or, which comes to the same thing, the mother of the syphilized child may show no trace of the disease herself.

SYPHILITIC ABORTION.—One of the commonest effects of syphilis in a pregnant woman is the production of a diseased state of placenta, by means of which the fœtus is starved, and perishes, and is aborted. The author believes that this usually commences in the decidual portion, which becomes indurated, thickened, and impervious, so as to spoil lobule after lobule of the placenta, hindering the circulation of maternal blood through it, and inducing, as a subsequent change, atrophy of the villi of the chorion. On the other hand, the child may die from syphilitic disease, and atrophy of the placenta follow.

SYMPTOMS IN THE INFANT.—Some children are born puny, shrivelled, and with eruptions on them; but far more frequently the child, if it reach the full time alive, is well nourished and plump. In some of these cases the writer has been struck with the remarkable volume of the placenta, owing to hypertrophy of the decidual element, and a peculiar staining of pinkish colour.

If a child be born healthy, the first manifestations of syphilis occur usually within a month, rarely later than three. The first symptom usually noticed is *snuffles*, a noise arising from purulent mucus in the nose; then follow papulæ on the palms and soles, and about the anus and scrotum, or female vulva: these are succeeded by mucous patches, which also appear in the mouth, and desquamation of cuticle from the tongue. If the disease go on, flat vesicles appear on the eyebrows, head, and body, leading to shallow ulcers with dusky margins, and covered with scabs. The anæmia and feebleness, and jaundiced tint, which accompany these symptoms show that the liver is probably affected, and in severe cases phthisis and atrophy prove fatal, and suppuration of the thymus is said to occur.

TREATMENT.—Few therapeutical processes are more easy and agreeable than the treatment of congenital syphilis, when the child is cleanly kept and properly fed. All that is needed is to smear about ten grains of blue ointment every night on the soles of the feet, and let the child wear socks day and night. The first thing noticed in a few days is an improvement in nutrition and general well-being; then the local symptoms amend. This improvement in the process of healthy blood-making under mercury, and the existence of anæmia as a *first* sign of relapse, are remarkable. In three weeks or thereabouts the course

be discontinued, and be resumed again when fresh symptoms
. The writer has had ample opportunity of observing that
ile syphilis is liable to relapse, no matter whether mercury be
ued or no, and that it is best to discontinue the drug for a time,
n as the maximum of benefit to the general health is attained.
symptoms should be treated with soap and water, black wash,
th ointment, &c.

the parents display any symptoms of syphilis, they should be
l for it and be kept apart till cured. When the woman becomes
nt again, shall any preventive treatment be adopted? The
r advises it decidedly, on the ground that alterative mercurial
ent can do no harm, and that it is the best mode of relieving
of the placenta, whether it arise from syphilis or scrofula. The
medies are blue pill and conium at bedtime, with small doses of
e daily: corrosive sublimate in smallest doses, with sarsa, bark,
cture of steel. F. 63, 83, 87, &c.

CONGENITAL SYPHILITIC TAINT often pursues children to a late
of life. It may or may not affect the general growth and
pment. This depends on the degree to which the latent diathesis
en called into play, and the amount of actual disease which has
d. The symptoms which in young adults testify to their having
d from syphilitic disease in childhood, are these: first, *Hutchin-
teeth*.* The *permanent* teeth (not the milk teeth), and especially
ntral incisors of the upper jaw, are short and narrow, with a broad
al notch in their edges, and their corners rounded off. The ac-

nying drawing of the teeth of the young man mentioned at
will shew what is meant. It is not horizontal notches, nor

called, after the pattern of "Bright's" disease, in honour of Mr. Jonathan
ison, to whose patient and laborious researches we owe almost all we
of the history of hereditary syphilis after childhood. See his Clinical
s on Diseases of the Eye and Ear consequent on Inherited Syphilis,
1863, p. 204.

loss of enamel, which is often seen in the second teeth of strumous persons, but the peculiar appearance here depicted which is the characteristic. "The skin," says Mr. Hutchinson, "is almost always thick, pasty, and opaque. It also often shows little pits and scars, the relics of a former eruption, and at the angles of the mouth are radiating linear scars running out into the cheeks. The bridge of the nose is almost always broader than usual and low; often it is remarkably sunk and expanded. The forehead is usually large and protuberant in the regions of the frontal eminences; often there is a well-marked broad depression a little above the eyebrows. The hair is usually long and thin, and now and then (but only rarely) the nails are broken and splitting into layers. If the eyes have already suffered, a hazy state of the cornea, and a peculiar leaden lustreless condition of the irides, with or without synechiæ may be expected. If, however, the eyes have not yet been attacked by syphilitic inflammation, they will present no deviation from the state of perfect health and brilliancy. The occurrence of well-characterized interstitial keratitis is now considered by several high authorities as pathognomic of inherited taint." Frequent abortions and loss of the earlier infants of a family are also suspicious. Iritis, in infants from about six to fifteen months; *scrofulous corneitis* between the age of eight and fifteen; inflammations of the deeper structures of the eye; and deafness, are the special symptoms enumerated by Mr. Hutchinson as evidence that the patient has suffered heretofore from syphilitic disease. But as we before said, the syphilitic *taint* alone produces no visible symptoms unless some actual *disease* of mouth, skin, eyes, &c., have followed. Hence, a young adult may have truly syphilitic disease of congenital origin, but yet none of the foregoing signs of previous attacks.

Whatever form of disease can be provoked by scrofula may be imitated by syphilis; in every case, therefore, of inexplicable strumous or strumous looking disease in early life, the evidences of syphilis may be cautiously inquired for. The remedies are mercury, iodide of potassium with ammonia, and tonics. The two former should be used to relieve existing symptoms, but not to prevent future ones.

SECTION XI.—DOUBTFUL AND MIXED CASES.

TYPICAL CASES.—The student will meet with many cases which answer to the description we have given, and which may serve as patterns:—such are, ordinary gonorrhœa, followed or not by tenderness of inguinal glands, orchitis, and rheumatism; soft chancre, with or without suppurating bubo, and without secondary symptoms; pure hard chancre, with indolent glandular enlargement and secondary symptoms in six weeks. But many cases will be met with, in which one of these forms of disease will be combined with some other; or with the remains of a foregoing infection, hereditary or not, and which it will be extremely difficult to disentangle, and to identify with the pattern cases in books.*

* Of all these complications there is a perfect magazine of cases and illustrations in Dr. Jeffery Marston's papers, Med. Chir. Trans. vols. xlv. and xlvi.

? plus *hard chancre*. "It must always be borne in mind," says ce, "that the character of a sore at one time is no certain indica- f what it may previously have been, or of what it may ultimately ." It is therefore unsafe, even when a chancre has been watched the first, and is pronounced *soft*, to promise exemption from ary symptoms. For there may have been a twofold inoculation, ch disease may exist in one spot."*

rd plus *soft chancre*. A "hard," true infecting chancre, may the ulcerative and suppurative characters of the "soft" super- to it; from intense local irritation, dirt, &c., as frequently n with sores on the skin of the penis; or from cachexy. Such are inoculable, and leave little if any induration.

ecting sore plus *suppurating bubo*. Constitutional syphilis may a sore which has been attended with suppurating bubo, if the tation is scrofulous, or there has been much local irritation, or is mixed with soft chancre.

bon d'emblée followed by *constitutional syphilis*. There is no of this fact according to Benjamin Bell, Marston, and other rities, although whether *post* or *propter* be doubtful.

norrhœa followed by *infection*. Chancre may occur in the urethra, f too far down to be visible, may be indicated by more or less soreness and hardness at one spot, and detected by external ination, or by the bougie. Still there are cases adduced by on, showing that infection has followed cases of apparent rhœa, with indolent glandular enlargement, but without anything ulcer. Such cases are most explicable, according to Dr. Marston, nsidering them analogues of the very superficial and diffuse irri- n of the glans, which accompanies a small patch of infecting sore. er,† as is well known, succeeded in inoculating himself with an ing sore and constitutional syphilis by means of the matter from orrhœa. Whether, as Ricord suggests, the patient from whom atter was taken had concealed chancre, or, as Marston suggests, e syphilitic gonorrhœa, or, as Mr. Babington suggests, whether re were inoculated by means of a dirty piece of caustic, will pro- never be known. The fact remains.

Whilst these pages are in the printer's hands, the author has been favoured he following note by Dr. Jeffery Marston:—

e most useful description as well as the *most truthful*, of the infecting that it originates in a pimple, a papule, an erosion or abrasion, a crack sure, around which a thickening or induration ensues, but that hardness essential to the infecting sore. This hardening, according to Sigmund, in one or other of the three following conditions:—1. Hardening or in- on of *sore* and *glands*; 2. Hardening and induration of *cicatrix* and ; 3. Hardening and induration of *lymphatic glands* only, the original sion never having become hard. In doubtful cases I place a *great deal* ence upon the state of the inguinal glands, and Sigmund, who seems to have studied the subject very carefully indeed, looks upon this indura- f the lymphatics as of more importance than the character of the sore or charges." "Constitutional syphilis *may appear* whilst a patient has a re, and yet have nothing to do with it."

n the Venereal Disease, part vi. chap. ii. s. 2.

SECTION XII.—SYPHILIZATION.

SYPHILIZATION signifies the repeated inoculation of matter from a venereal sore, upon the same patient, either to render him insusceptible of fresh attacks, or to relieve existing symptoms. It was first devised by Auzias Turenne and Sperino of Turin, about 1850, and since, has been carried out on a very large scale by Professors Boeck, Faye, and other practitioners at Christiania and other parts of Scandinavia.

The only chancre that can be inoculated repeatedly is the *soft*; and it has been satisfactorily proved that after about four hundred inoculations, the system is still susceptible of the virus of the *hard* chancre, so that there is no protection in it. Nevertheless, it seems abundantly proved that obstinate constitutional syphilis, which has been rebellious to other remedies, has become subdued during this most strange and disgusting process.*

* See Bumstead and Henry Lee, op. cit.; Aperçu des différentes méthodes de traitement employées à l'Hôpital de Christiania, contre la Syphilis constitutionelle. Par J. L. Bidenkap. Christiana, 1863.

This book gives a series of cases treated by M. Boeck by syphilization, and another series treated by M. Hjort by that which comes nearest to it, *i. e.*, *derivation*, or the formation of a series of pustules by emetic tartar. Of course the rest in bed, hospital diet, &c., were the same in both cases, and there can be no doubt of the superiority of syphilization over derivation and over sweatings, &c., whether as regards the time required for the suppression of symptoms or the frequency of relapses. M. Bidenkap affirms the inoculability of the infecting sore—a thing we grant, if, as Marston and Lee have shown, there be a pus element superadded; for a hard chancre *suppurating* may be inoculated, not a hard chancre *per se*. At last, after from four to five months of syphilization, comes a time when inoculability ceases, and then the constitutional symptoms are cured. Syphilization, says M. Bidenkap, does by art for syphilis what is done spontaneously in small-pox by the eruption; it provides for the development and multiplication of virulent matter, during which a local and general immunity against any further action of that virus is established. "My experience is," says Dr. Jeffery Marston in a MS. note to the author, "that so long as an ulcer is open and spreading upon any part of the body in a constitutionally syphilized individual, no other manifestations may appear." We must accept these facts, though we cannot explain them.

PART IV.

INJURIES AND SURGICAL DISEASES OF VARIOUS TISSUES, ORGANS, AND REGIONS.

CHAPTER I.

DISEASES OF THE AREOLAR TISSUE.

Of the diseases of the areolar tissue, the greater number have been already sufficiently described, when treating of the elementary processes of disease, and effects of injuries. We have nothing to add to our account of inflammation; abscess, acute or chronic; diffused or erysipelatous inflammation; œdema, ecchymosis, and scrofulous ulcer. Of the inflation with air we shall speak under the head of emphysema; and of the injection of irritant liquids under the head of extravasation of urine. This tissue is the favourite seat of a great variety of tumours, especially the fatty, painful subcutaneous, fibro-plastic and allied species, encysted, and cancerous; for the diagnosis and treatment of which we refer to the Chapter on Tumours. Cancer in this tissue, whether superficial or deep, is rare as a primary affection, and is usually of the soft variety; but no doubt many of the cases heretofore reported as cancerous have been fibro-plastic.

CHAPTER II.

SURGICAL DISEASES OF THE SKIN.

I. HYPERTROPHY of the entire skin, which increases in breadth and length so as to project in pendulous flaps or ridges, is sometimes seen, and is sometimes congenital. If inconvenient, the knife is the remedy.

II. WARTS, or VEGETATIONS, are diseases consisting in an hypertrophy of the papillæ and cuticle. (1.) The commonest variety is the wart which frequently grows on the hand or face of children, and which consists of lengthened papillæ, each containing a vascular loop, and

clothed with dry, hard cuticle. If necessary to interfere, warts may be snipped off, or tied, or be touched with caustic; but they often return obstinately, in spite of treatment, and disappear of themselves when let alone. Perhaps the best plan is to divest them as much as possible of cuticle, and then cover them with mastic and tannin varnish. F. 183.

(2.) A second variety consists of hypertrophied papillæ, clothed with *thin* cuticle, especially apt to come on the inside of the thighs, perinæum, about the anus, within the prepuce, and in similar situations in and near the genitals of either sex, especially the female. Some are highly vascular, and easily bleed; some are pale and indolent; some broad and flat; some tall and stalked; all discharge a thin sour ichor; and are caused by the irritation of the discharges of gonorrhœa or of syphilis, combined with that of the natural perspiration of uncleanly persons. They may grow on the site of a healed chancre, or mucous patch, or secondary sore. These warts are commonly called *venereal warts*, because they are doubtless caused by the irritation of venereal discharges; they are contagious, and may produce similar warts in healthy persons.

Treatment.—If daily washing with soap and water, and with chloride of zinc lotion, F. 127, does not suffice, the most efficacious plan is to cut off all the morbid growths with the knife or curved scissors; and apply an astringent lotion during the cicatrizing stage. If they grow again, they may be touched with nitrate of silver, or some escharotic, such as one drachm of muriatic acid with three drachms of muriated tincture of iron; liquor plumbi diacetatis; creosote, or the acid nitrate of mercury.

(3.) A third variety is the wart which comes on the face of some other part of the skin of elderly persons, and, after a time, becomes the seat of epithelioma. With this may be classed the chimney-sweeper's wart of the scrotum, the warty growths which are the first stage of so-called *cancer*, *epithelial cancer*, or *cancroid* (or properly speaking, *epithelioma*), of the lip and penis, and the *warty tumour of cicatrices*, described by Cæsar Hawkins, which begins as a simple wart on the site of an old scar, increases, ulcerates, throws out huge fungous masses; contaminates the glands, and causes death by the pain and exhaustion of foul ulceration.* See *Epithelioma*, p. 110.

III. CORNS are growths of thick cuticle, not merely lying upon the true skin like *callosities*, but penetrating into it. They are produced when the skin, situated over some projecting point of bone, is irritated by pressure or friction. Their usual seat is on the joints of the toes, and tight boots or shoes are their usual cause. They are divided into two kinds, the hard and the soft. The hard are situated on the surface of the foot, where the cuticle can become dry and hard; the soft between the toes, where the cuticle is soft and spongy. We must observe, however, that what are called *soft corns* between the toes, are

* Cæsar Hawkins, Med. Chir. Trans. vol. XIX.; R. W. Smith, Dublin Quarterly Jour. Med. Sc. May, 1850; Hannover, Epithelioma, &c.

not always corns, but excessively irritable fungous warts, and consist of a growth from the cutis vera, not of a mere thickening of the cuticle.

Treatment.—The points to be attended to are, to have the boots or shoes properly adapted to the shape and size of the feet;—to wash the feet every night, and to rub the corns every morning with a little Naples soap, or some other kind of soap just moistened. If very painful they may be poulticed at night, and kept moist by day with glycerine, so that they may be kept soft and pliable, not hard and dry. If these measures be adopted, and the part relieved from pressure, the corn will soon peel off.

But some feet are so misshapen originally, or the toes are so crowded together by wearing small, low, pointed shoes, that it is impossible to contrive any shoes that will not press and create corns somewhere. In some of these cases the application of a plaster of thick soft leather, having a hole punched in it to receive the corn and relieve it from pressure, is a very useful device. If the corn is on the sole of the foot, a piece of felt, or small fold of flannel may be arranged so as to relieve it from pressure. For the soft corns between the toes, and for very irritable corns, the nitrate of silver is the best application. When a corn inflames, and matter forms beneath it, the pain is most excruciating, and only to be relieved by paring it down and letting out the fluid.*

IV. HORNY TUMOURS are formed by an inspissation of the matter of the sebaceous follicles, and by laminated growths of epithelium from their interior. They are easily removed by two oval incisions.†

V. WENS are encysted tumours, most common on the head, face, and shoulders, consisting of obstructed sebaceous glands (whose orifice may often be found in the form of a small black spot or crust), or else of erratically-developed cutaneous cysts. The matter contained is a collection of epidermic scales with hairs, oil-globules, and crystals of cholesterine, and has received the name *atheroma* or *steatoma*, from its resemblance to gruel or suet. Distension, suppuration, ulceration, and fungous granulation of the interior of the cyst sometimes occur.

Treatment.—If an aperture is visible, and the tumour is not very large, it may be opened by a probe or director, and the contents be pressed out. Otherwise, it may be extirpated entirely by running a scalpel through it, seizing the cut edge of the cyst, and gently tearing it out with a touch or two from the knife. If the wen is much inflamed, it may be laid open by a free incision, and be allowed to discharge its contents into a poultice, then to suppurate and contract.

VI. CHELOID TUMOUR (*Kelis*).—This consists essentially in an hypertrophy of the tissue of the true skin, intermixed with fibroplastic matter. It presents itself in the form of one or more projecting tumours, or of thickened reddish patches, in the substance of the

* Brodie, Lecture on Corns. Med. Gaz. vol. xvii. p. 775; Key on Bunion. Guy's Hosp. Reps. vol. i. p. 416.

† Vide Erasmus Wilson, Med. Chir. Trans. vol. xxvii.

skin. The most frequent situation is the chest; but such tumours are partial to the site of cicatrices (especially in people of colour, and soldiers after flogging), and are often multiple. Occasionally superficial ulcers occur; but in most cases this disease leads to no ill consequences. It is extremely liable to return after extirpation. Iodine and arsenic should be cautiously tried, F. 94, 97.*

VII. MOLLUSCUM.—A malady consisting in the development of numerous tumours on any part of the body where hair grows; varying in size from that of a small shot to that of an orange; hard and painless; either embedded, or prominent and stalked; sometimes exuding a milky fluid from a minute aperture; consisting, according to Dr. L. Beale, of an alteration of the hair follicles, and hypertrophy of the areolar tissue. Probably the chloride of arsenic, if resorted to early, might cause diminution of the tumours (F. 97). But if one or more becomes very inconvenient, it may be cut out.†

VIII. MOLES.—Oblong patches of imperfectly-organised skin with black matter in its interstices, small vascular patches, and other congenital imperfections of the skin, should be extirpated, if at any time they seem inclined to spread and become irritable, because it is possible that they might become the nidus of epithelioma, or of cancer. The health should be carefully watched under such circumstances.

IX. CANCER of the skin may be a result of the propagation of the disease from the breast, or from some gland; or may be primary. Sometimes it affects the scirrhous form, and presents itself in the shape of one or more hard tubercular dull-red masses; sometimes it begins as an innocent-looking, but rapidly-growing wart, which speedily assumes the characters of soft cancer; bleeds or exudes a sanious liquid, and contaminates the nearest glands. The melanotic variety is also common. It is a frequent occurrence that cancer is deposited in warts, moles, and similar growths; and it is possible that it may be combined in one tumour with epithelioma. For the clinical history and treatment we must refer to the Chapter on Cancer.

X. BOIL (*Furunculus*).—A circumscribed round hard swelling, depending on inflammation of one spot of the true skin, and on the deposit therein of unhealthy lymph; usually attended with the acutest pain and tenderness; and ending in suppuration, and the discharge of a flake of softened lymph, and a small sloughy shred of areolar tissue, which form what is called a *core*. It is caused by blood disorder, from unwholesome food, or from unknown epidemic atmospheric causes, or from depressing influences generally. It may be acute, with great pain, swelling, and fever; or chronic, indolent, hard, and slow to suppurate; or may come out in crops, one coming so soon as the preceding one is healed.

Treatment.—If acute, poultices; and so soon as suppuration is fully

* Warren on Tumours, p. 40; Burgess's Translation of Cazenave, p. 35; Mayo's Pathology, p. 236; Lebert, sur les Maladies Cancéreuses, p. 682; Longmore, Med. and Chir. Trans. vol. xlvi.

† Bateman, Cutaneous Diseases; Lionel S. Beale, Pathological Trans. vol. xi.

lean cut with a sharp lancet: if, however, the lump be
n does no good; during the last stage of the acute, and
le course of the chronic, stimulating applications, such
ruvian balsam ointment; or painting with tincture of
constitutional treatment must be at first eliminative;
wels should be emptied, and the tongue cleaned by a
f calomel, &c., F. 37 or 38; and the diet should be re-
successive crops come out, alteratives and tonics should
liquor potassæ in drachm-doses twice daily (or the liq.
red John Hunter) has a good reputation in these cases;
rs it has more frequently failed than not, and it appears
ecially the preparation of bark with acids F. 1, &c., are
l remedies. Where there is no obvious derangement of
alth which may serve as a key to the treatment, and
remedies fail, a thorough change of air should be tried.
effected many cures by sending the patients to Paris,
urse of tonic and alterative treatment.

NCLE (*anthrax*) is an exaggerated boil. An oval or
n of skin, varying in size from that of a hazel nut to
; or, perhaps, very much larger, becomes infiltrated
lymph, forming a hard, dull-red swelling; very tender,
ching pain. After a few days of gradual increase, soft-
puration occurs at several parts, which become of a
more prominent, and yield an obscure sense of fluctua-
lows ulceration of these points, forming round apertures,
thin ichor; but if pressure be made, a thick glutinous
e squeezed out. The ulcerated apertures enlarge and
ichid stuff is discharged, mixed with softened fibrous ex-
ith sloughs of the areolar tissue, and the wound slowly
heals. Such is the course of carbuncle, if left to
ways an indication of vitiated blood, and has the same
as the boil, but there is some utterly unknown cause,
luced a most extensive visitation of these maladies during
ars. When large, especially if situated on the head or
e to be attended with violent fever, followed by great,
fatal prostration of strength. The *treatment* is that of
nce it is a blood disorder, efficient means should be taken
luce a full discharge of bile and urine, F. 33, &c. The
l be kept up by soup, and brandy or wine, at discretion.
l be given to allay pain, and quinine or Liq. cinch. fl.
d to recruit the strength. Fomentations and poultices
to hasten suppuration. It is generally agreed that the
hastened by measures for letting out sloughs and dis-
me cases it is beneficial to cut through the swelling
d brawny; but it is usually better to defer this till sup-
mmenced, and then thoroughly to cut through the infil-
and insure a free discharge of all pus and sloughs; after
arm poultices with the resin or creosote ointment.

Mr. Pritchard, in his able Surgical Address before the Brit. Med. Assoc., at Bristol, in 1863, advocated the use of caustic potass, as less liable to risk of pyæmia from entrance of matter into gaping vessels, and as more thoroughly softening the sloughs and insuring their discharge.

CHAPTER III.

DISEASES AND INJURIES OF MUSCLES, TENDONS, AND BURSÆ.

I. SIMPLE ATROPHY of muscle, with more or less fatty degeneration, may arise from want of exercise, however caused. Moreover, it sometimes happens, that after a fever, or after injury, or disease, or exposure to cold, or after some affection of the nervous centres, one arm, or one leg, or both legs are smitten, as it were, with a blight. The affected member is always chilly; its skin is numb: it is imperfectly nourished, and decreases in bulk; if the patient is young, it ceases to grow in proportion with the other parts of the body; and its flexor muscles often become affected with rigidity, so that the joints are immoveably bent and contracted.

Treatment.—Steel, quinine, cod-liver oil, and other tonics; warm clothing and liberal diet; stimulating frictions, affusion with cold water, passive exercise, shampooing, and electricity or galvanism, so as to keep the muscular fibrillæ exercised.

II. INFLAMMATORY SPASM is a malady of which the commonest example is the *stiff neck*, or rheumatic inflammation and spasm which affect the muscles of the neck after exposure to cold, in persons whose blood is imperfectly purified. But it may affect any other muscles. Purgatives and fomentations usually soon produce a cure. We may remind the surgeon of the frequent recurrence of—

III. MUSCULAR SPASM as a symptom either, 1st, of irritation of the bowels or other internal organs; or 2ndly, of disease in the nervous centres.

Of the former class of cases, spasm of the sphincter ani, of the muscles of the hip, and of other parts in children whose intestines are loaded, are examples. Of the latter, the spasm which attends hemiplegia, with irritation of the brain.

IV. RIGID ATROPHY is a state in which a muscle becomes short, rigid, and inextensible; generally causing displacements and deformities of the parts to which it is attached. *Causes.*—1st. It may be induced by *long inactivity* of the antagonist muscles;—thus, after long-continued disease of the knee, the flexor muscles of the ham may become shortened and inextensible, keeping the joint permanently bent, and often dragging the tibia off from the condyles of the femur. 2ndly. It may be a sequel of *habitual spasm*, by whatever cause produced.

Treatment.—In the early stages, friction, shampooing, and mechanical extension. But in cases of long standing, the only remedy that can

be relied on is *division* of the affected muscle or of its tendon; by which means the divided parts will retract; they will unite by lymph, and will consequently be lengthened, and then extension may be practised with greater efficacy. (See *Clubfoot* and *Wry Neck.*)

V. ACUTE ATROPHY.—In this affection one or more muscles rapidly waste away, and their wasting is attended with severe pain, especially in the course of their nerves. It appears to depend on rheumatism of the muscular nerves, and to be caused by cold.*

VI. RUPTURE OF MUSCLES AND TENDONS.—This is an accident which is frequently caused by violent muscular contraction; especially if, after illness or long inactivity, the muscles are subjected to sudden and severe exertion. The muscles which are most frequently ruptured are, the gastrocnemius, the rectus femoris, which sometimes is entirely detached from the patella,† and the biceps flexor cubiti; but more frequently the tendons give way, especially the tendo Achillis, and flexor tendons of the wrist.

The *symptoms* of this accident are, sudden pain, and sometimes an audible snap. The patient cannot extend the tendon as he can in the opposite limb. A depression may be felt with the fingers at the ruptured part.

The reparation of ruptured tendons, and of tendons divided by subcutaneous section, is accomplished by the exudation of lymph between the severed extremities and into their sheath. This quickly sets into a homogeneous substance, minutely granular and studded with elongated nuclei, which speedily assumes the fibrous characters and consistence of tendon.‡ This process proceeds best when unaccompanied with extravasation of blood, or with inflammatory exudation.

Treatment.—The main point is to keep the injured part in a state of constant rest and relaxation,§ so that the severed ends may be in close approximation, and to prevent any violent extension till union is firm. When the tendo Achillis, or the gastrocnemius muscle is ruptured, the knee may be kept bent by a string passing from the heel of the slipper to a bandage round the thigh. For ruptures of the extensors of the thigh, the limb must be placed in the same position as in fracture of the patella. If the biceps is ruptured, the elbow must be kept bent to its utmost; if the tendons about the wrist or fingers, the forearm must be confined by a splint. After three or four weeks of rest, the surgeon may use *passive motion*; that is, may bend and extend the joints of the injured limb with his hands several times successively. But the patient must be cautious in using the muscle for a long time; and (if it be the tendo Achillis) must walk with a high-heeled shoe for two or three

* Two cases of it are given in Mayo's Pathology, p. 317. The author has seen several, which all attempts have failed to cure.

† Vincent, op. cit. p. 71.

‡ See Mr. William Adams's account of the Reparation of Tendons, Trans. of the Pathological Soc. vol. vi.

§ Muscles are to be relaxed by putting them into a position the reverse of that which they occupy when in greatest action—not by merely approximating their attachments.—Vincent, p. 11.

months; so that the recent callus may not be stretched and lengt which would cause permanent weakness.

VII. SPRAINS.—A sprain signifies a violent stretching of ten or ligamentous parts, with or without rupture of some of their It produces instant severe pain, often attended with faintness great tumefaction and ecchymosis; with subsequent weakness an ness. If the part is not kept at rest, or if the diet is intemper the blood impure, and if the knee or some other large joint is af there will be great pain, inflammation, and fever, that may l serious or even fatal results.

Treatment.—The most essential measure is perfect rest; and sure this, the patient should go to bed, and if the part affected knee, it should be confined by a pasteboard splint. During th day or two, the object is to allay pain, and to anticipate inflamm effusion. Warm fomentations, henbane, an aperient, and plain d the measures. If *inflammatory* pain (that is, throbbing bea swelling, not the mere pain of the injury) should be developed, l should be applied; otherwise not. Then the best thing is to p the part by a firm bandage, so that the reparative process shall disturbed; and once daily to foment it well with hot water, an it with a stimulating liniment. If after a sprain, the part inj liable to fits of inflammation, and very slow in recovering its p treat it as if chronic rheumatism (p. 44) by iodide of potassium

VIII. ACUTE INFLAMMATION OF THE SHEATHS OF TENDON FASCIÆ is generally caused by punctured wounds, especially by ture of the fascia of the biceps during venesection; and by pun of the fingers, inflammation of the tendinous sheaths of which is *thecal abscess; paronychia gravis*, or *tendinous whitlow*. It is at with severe, tensive, throbbing pain; exquisite tenderness; sligh tense and resisting swelling; and very great constitutional distur It may lead to suppuration; the matter extending itself along n and tendons, from the fingers to the forearm, causing sloughing tendons, severe irritative fever, life in danger, and the limb le and useless.

Treatment.—If the pain and tension increase, notwithstandi employment of leeches, fomentations, and purgatives, *free in* must be made through the inflamed parts; in order to give v matter, if it have formed, or by creating a free discharge of bl prevent its formation.—See *Whitlow*.

IX. CONTRACTION AND RIGIDITY of the fasciæ are exempli *contraction of the palmar fasciæ*.—See the Index.

X. TUMOURS OF TENDON AND LIGAMENT.—Small fibrous tu about the size of a pea, are apt to form on the tendons or Sometimes they follow a sprain. The author knows an eminent cian, on whose palmar fascia such small tumours appeared after fully long practice at the piano; but they often arise without an cific exciting cause, probably from some rheumatic taint. The of potassium is the best remedy, F. 94.

CHALKSTONE DEPOSITS are composed of the lithate of soda; a soluble substance, which in gouty subjects is frequently depo- ito the texture of the bones, joints, and cellular tissue, but equently into the cellular tissue that environs the tendons of or hands. These deposits may be permeated by exquisitely- threads of cellular membrane. After remaining indolent for a time, they may inflame the superjacent skin, and cause the on of ulcers that are extremely obstinate, and discharge vast

ies of the concretion. They must be treated with simple dress- It is rarely expedient to meddle with these tumours with the but if any one be very inconveniently situated, and be perfectly it, it may be extirpated. The wound must be expected to heal owly.

GANGLION.—This is an encysted tumour formed by the sheath ndon, or by a new cyst developed in one of the fringes of the l sheaths, or by a bursa, whether original ated by friction. When recent, it is olent fluctuating tumour, transparent to permit the light of a candle to be rough it. It contains a clear synovia; or viscid and semifluid. Not unfre- y this fluid contains a number of small es of a millet-seed shape, which are floating loose in a thin fluid, but appear w from some part of the lining of the and afterwards become detached. The y situation of ganglion is that of the bursæ; on the patella or olecranon, the inner side of the head of the tibia, angle of the scapula; but most fre- about the wrist, fingers, and back hand in connexion with the extensor s. In this situation it is often the of a sort of hernial protrusion of the al membrane lining the sheath through idental opening in the fibrous sheath When the general sheath of the flexor at the wrist is affected in this way, s a remarkable tumour, which pro-

ganglion, formed by the synovial sheath of the flexor tendon of a finger.

jects in the palm of the hand, and also above the wrist, but is bound down in the middle by the anterior annular ligament of the carpus. Considerable pain and weakness are caused by these swellings. When ganglion has lasted some time, or has been subjected to inflammation, the cyst becomes thickened, and the tumour loses its softness and transparency. The ordinary cause of ganglion is a twist or strain of some kind, or irritation from pressure or friction, or from a rheumatic change in the lining membrane and its secretions, or some unknown constitutional tendency.

Treatment.—(1.) The best plan of treating recent non-inflamed ganglion seems to be, either to burst it by pressure with the thumbs, or to puncture it with a grooved needle, or else to make a subcutaneous incision into the sac; that is, to introduce a needle with a cutting point, and to turn the point against the inside of the sac and divide it, without, however, making a larger wound in the skin than is necessary to introduce the needle. The object of these operations is to empty the sac, and form an aperture by which its contents may henceforth pass into the cellular tissue and be absorbed. As soon as it is emptied, constant pressure should be applied by means of compress and bandage, which may be wetted with cold lotion, if agreeable. (2.) If this plan fails, recourse may be had to blisters, friction with mercurial and other stimulating liniments, or Scott's ointment, F. 160, or the *iodine paint*, F. 89. (3.) In obstinate cases, if it is a bursa (as over the patella or olecranon), and has no connexion with the sheaths of tendons, it may be dissected out. (4.) But if the bursa is large or deeply seated, as over the angle of the scapula, it may be freely cut into and emptied, after which it will probably heal up. (5.) In obstinate cases, especially if the cyst is much thickened, a puncture may be made, and a few threads of silk, or a wire, be passed through the sac as a seton. This destroys the secreting power of the sac, and effects a radical cure, but the operation requires great discretion, as it may be dangerous to life. (6.) Ganglion of the flexors of the wrist should not be tampered with incautiously. If an operation is necessary, Mr. Fergusson prefers a free incision, as less dangerous than puncture. (7.) Mr. Wickham strongly recommends the vapour bath, or local steam bath, as a means of getting rid of thickness and stiffness after these operations. Lastly, any rheumatic or gouty tendency should be corrected by proper medicines.*

XIII. ACUTE INFLAMMATION OF BURSÆ is most frequently exemplified in the affection called the *housemaid's knee*, which is an acute inflammation of the bursa that intervenes between the patella and skin, common enough in that class of females, from kneeling on hard damp stones. It causes very great pain, swelling, and fever; it may be distinguished from acute inflammation of the synovial membrane of the knee-joint, by observing that the swelling is very superficial, and in front of the patella, which is obscured by it; whereas in inflammation of the synovial membrane of the knee, the patella is thrown forwards, and the swelling is most prominent at the sides.

* See an abstract of a paper by Coulson, in Ranking, xiv. 279.

Treatment.—Rest, leeches, fomentations, and purgatives; by which, if the pain and swelling are not relieved, a free incision should be made into it.

XIV. LOOSE CARTILAGES, and melon-seed-shaped excrescences, are sometimes formed in the synovial sheaths of the hand and foot as they may be in the joints. They may be removed by subcutaneous incision.

CHAPTER IV.

DISEASES AND INJURIES OF THE LYMPHATICS.

I. ACUTE INFLAMMATION of lymphatic *glands* has already been explained when speaking of bubo. The inflamed gland enlarges rapidly, and forms a hard, tense swelling, with great pain and fever. If it suppurate, there may be shivering, delirium, and intense constitutional disturbance, till the pus is evacuated. The affection may be caused, 1. Like any other acute abscess, by constitutional disorder. 2. By local violence, such as blows or kicks. 3. By the irritation or absorption of acrid matter from ulcers, blisters, or eruptions of the skin. 4. By simple injuries, a clean prick, for instance, in persons whose health is deranged. 5. By punctures inoculated with some irritant fluid, perhaps from a putrid body.

When the disease arises from ulcers or punctures, the inflammation generally begins in the lymphatic *vessels* leading to the glands, which appear as red lines under the skin, and feel hard, cordy, and tender. If one of the fingers has been poisoned, there will be inflammation at the seat of injury, tender red lines extending up the front of the forearm, and a tender enlarged gland just above the inner elbow.

When pain and fever are intense, it will be right to apply leeches, and afterwards warm fomentations; but in most cases, especially when the cause is constitutional, and the disease is allied to idiopathic abscess, it will be better to induce suppuration as soon as possible, by fomentations and poultices; and so soon as pus has formed, it should be discharged by free incision. The constitutional treatment must include moderate purgation, vegetable salines, F. 58; and the other measures directed for acute abscess, and for dissection wounds.

II. CHRONIC ENLARGEMENT of these glands, is, 1, most frequently caused by deposit of exudation in scrofulous persons. One or more glands become enlarged; usually the submaxillary or cervical; during the early years of life they may suppurate, or the swelling may entirely subside, or may remain during the whole of life.—See *Scrofulous Diseases*.

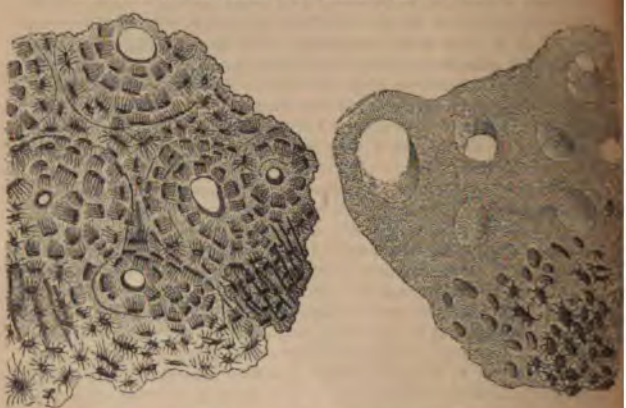
2. *Hypertrophy*, or infiltration with fibro-plastic matter, may convert one or more glands, especially in the neck, into hard, indolent, slowly-growing tumours; to be treated by cod-liver oil and iodide of iron or of potassium; and if these fail, by the knife.

3. *Cancer* of the lymphatic glands is usually a secondary affection, as we have before described. More rarely they are the primary seat of the disease, which then is more frequently soft cancer than hard. The diagnosis at first may be difficult, especially between soft cancer commencing in young subjects, and any other form of enlargement. But the rapid progress of the soft cancer, and the failure of health, which is sure to ensue after a certain time, will be leading distinctions.

CHAPTER V.

DISEASES AND INJURIES OF THE BONES.

SECTION I.—DISEASES DEPENDING ON HYPERTROPHY.



I. Microscopical Characters of Diseased Bone.—When a thin transverse section of diseased bone is examined under a good microscope, the observer readily distinguishes some large round or oval apertures—sections of the Haversian canals which convey the blood-vessels. Around these the bone—an obscurely-granular substance—appears to be arranged in concentric laminæ, containing amidst the laminæ the bone cells, with the canaliculi or minute pores projecting from them. Larger vacuities in the bone, visible to the naked eye, contain the marrow and veins. Now it appears, from the researches of Mr. Tomes and of Mr. Campbell De Morgan, that bone during life is in a state of constant absorption and renewal. Fresh Haversian canals are being incessantly tunnelled out in the solid bone, and older ones are filled up. This is evident from

gaps and breaks in the laminæ, from the irregular and some of the Haversian canals, and from the evident way nd small Haversian systems are intruded into larger pre- The soft parts which fill the medullary cavities and the ls, thus evidently have the power of absorbing the bone y are in contact.

pical changes observed in diseased bone consist in differ- antity and quality of the bone structure, and in the nature es which fill its cavities.

bone, which is unusually dense and heavy, with few to the naked eye, the minutest structure is also con- versian canals small, the corpuscles opake, and arranged laminæ. 2ndly. In bone which is loosened out and aversian canals are large, defined, the corpuscles ill in the second figure,

medulla and other struc- l the bone cavities, may eased; they may be con- cells may be atrophied; inflammatory exudation, cer, and the bone may be free oil.*

HYPERTROPHY.—It some- hat one or more bones in- th and breadth, without from their healthy struc- tibia, or fibula, or femur, n to become enlarged and r some disease which has creased flow of blood to l the superior maxillary converted into a solid mass bliteration of the antrum. from common nutrition enlargements depend, is ntrolled by medicine, al- drug is likely to be of ser- odide of potassium.

OSIS signifies a tumour irregular hypertrophy of mours are hard, painless, nd mostly situated on the

by Mr. Tomes and Mr. De Morgan on the Structure of Bone, and a review of it by R. Druitt in the Brit. and For. Med. 3; and Wedl, Patholog. Histology, published by the Sydenham

upper part of the humerus, or tibia, or on the lower part of the femur, near the insertion of the adductor magnus. Their *shape* is sometimes broad and flat; sometimes rounded and prominent, with a narrow neck. Their *structure* is that of ordinary bone, sometimes dense and compact, especially when they grow from the frontal or temporal bones; sometimes porous in the centre, with a thin external cortex. Sometimes they result from the ossification of a fibrous, or fibro-plastic, or cartilaginous tumour or node of the periosteum; sometimes they are bony from the first, and are formed, as it were, by a development of one particular part of a bone, perhaps a natural process or spine. The preceding figure is an illustration. They cause no pain, unless they happen to press on nerves or arteries; but they may by their bulk interfere with the functions of various important parts, and give rise to the most serious evils. When situated on the inner surface of the skull, they may cause epilepsy; in the orbit they may cause the eye to protrude on the cheek; they may obliterate arteries, and impede the action of muscles, and the movements of joints. Sometimes they arise without any very obvious cause; occasionally they originate in a blow, or strain, or in an unnatural degree of pressure on a bone thinly covered by soft parts.

Treatment.—In the first place, an attempt may be made to procure absorption of the tumour by means of iodide of potassium and friction with ointment of mercury or iodine. The more recent the tumour, the more effectual such measures are likely to be. In some cases (especially if the complaint follow a blow), a moderate course of mercury, so as barely to affect the mouth, will be effectual. If these measures do not succeed, the tumour may be removed by operation, if requisite on account of the inconvenience it produces. If it is globular, with a narrow neck, it may be cut down upon, and be sawn or chiselled off, or cut off with a gouge. But supposing that its base is broad, so that this cannot be done, its periosteum may be shaved off; after which it will probably perish by necrosis, or else waste away; or the nitric acid, or potassa fusa, may be applied to its surface, to cause it to exfoliate. But these operations are not to be undertaken without due forethought; for they may be followed by extensive inflammation and necrosis, or by suppuration into a joint; and in operating on an exostosis near a joint, the possibility of opening the synovial membrane should always be considered. Exostoses of the clavicles of children almost always disappear of themselves.*

SECTION II.—DISEASES DEPENDING ON ATROPHY AND DEGENERATION.

I. ATROPHY of the bones is marked by a diminution of their weight. Sometimes it is attended likewise by a decrease in bulk; but sometimes, whilst the outward bulk is nearly unaltered, the proper

* Vide Sir A. Cooper on Exostosis, in Cooper and Travers's Surgical Essays; Mayo's Pathology, p. 11; Stanley on Diseases of the Bones, Lond. 1841; T. B. Curling on Atrophy of Bone, Med. Chir. Trans. vol. xx.

is withdrawn, the cortex being reduced to a thin shell, and
li to a few fine threads with their interstices filled with fat.
ndition the readiness with which the bones become broken has
to the appellation *fragilitas ossium*. Atrophy may be caused
and want of exercise simply; by disease of an adjacent joint;
ption to the supply of arterial blood; (thus, after fracture
ion of the medullary artery, the lower part of the tibia and
d upper part of the humerus, may undergo atrophy;) by that
lefect of nutrition which sometimes causes all the structures of
be withered and blighted; (vide p. 17), by old age; and by
ar state of the system which accompanies fatty degeneration,
nd mollities ossium.

CKETS, OR RACHITIS, is a peculiar unhealthy condition of the
ly, arising from hereditary taint, or else from defective hygi-
litions, and especially from want of fresh air and of bright
t is frequently attended with scrofulous disease; but its
haracteristic is the imperfect development, atrophy, and dis-
some or many of the bones. These are soft, and consist of
of cartilaginous tissue, which will
out breaking, and through which a
be readily passed." According to
omes and De Morgan, rickety bone
ructural arrangement of bone with-
pregnation with earthy salts. The
extremities of the bones are often
tionately large. The shafts are
support the weight of the body
bending. In moderate cases, the
ly may be a little sunk, or the shins
he spine curved; but in aggravated
physiognomy and general appearance
peculiar. The stature is stunted;
large, with a protuberant forehead.
nelles are slow in closing; the face
l triangular, with a very sharp-
in, and projecting teeth; the chest
nd prominent in front, whence the
rm *pigeon-breasted*; the spine va-
rved; the pelvis small; the pro-
f the sacrum and acetabula pressed
rendering the cavity perilously small
-bearing; and the limbs crooked,
ral curves being increased. Hyper-
the white substance of the brain,
stence of the thymus gland to a
od than natural, are said to be ac-
nts of rickets. This disorder gene-
cks the children of the poor from the second to the tenth or

twelfth year of their age. After puberty, it is astonishing how firm the bones become, and, in particular, how they are strengthened by strong ridges developed on their concave sides.

Treatment.—The health must be invigorated by sunlight, pure air, animal food, cod-liver oil, iron, and the other measures prescribed for scrofula. To these remedies, the author recommends *phosphate of lime* to be added, F. 201. When a child with crooked legs is brought to the surgeon, he should ascertain whether the deformity arises from relaxation of the joints merely—the bones remaining straight—or from crookedness of the bones themselves. For the knees and ankles may be greatly bent inwards from the former cause, but will become straight of themselves when the health becomes stronger, especially if salt bathing and frictions are used to the legs and back. But if the tibia or femur are actually bent, the surgeon must take care not to tell the parents that the child will *grow out of it*; for there is no evidence that a bone which has once yielded can ever recover its primitive shape spontaneously. Therefore some mechanical contrivances should be used, in order both to strengthen the bent bones, and to keep them so till they are strong enough to bear the weight of the body; and a pair of simple wooden splints, well padded, and applied with some degree of tightness, from the top of the thigh to the foot, seem to answer every useful purpose, and the child soon learns to walk about in them with his knees straight. They should, of course, be taken off once daily for a good washing and rubbing.*

III. Mollities Ossium (*Malacosteon, Osteomalacia*) is a disease generally, but not invariably, affecting elderly females, in which the bones become softened and brittle, and lose their earthy constituents. In the very first stage, the affected bones are softened and extremely vascular. As the disease advances they become somewhat thickened, and so soft as to be easily cut with a knife. On a section being made, the osseous tissue is found nearly absorbed, a mere shell being left, which in most cases is filled with "a dark grumous matter, varying in colour from that of dark blood, to a reddish light liver colour." Under the microscope the Haversian canals are found to be dilated, the osseous cells diminished, and the colour to be owing to the numerous oil-globules with which the bone abounds, and to the presence of blood pigment. As the disease advances, the affected bones seem to be reduced to mere thin shells, filled in some cases with serum, in others with fat; while in some instances all bony matter whatever has disappeared, and the periosteum has been left as a cylinder filled with a dark fatty substance of the consistence of liver.

The disease is evidently constitutional, and usually affects almost every bone in the skeleton, although two instances have been reported to Mr. Solly, by Mr. Hodgson, of Birmingham, in which it was confined to the lower extremity; and in one of these, amputation was performed. Moreover, it is liable in women to affect the pelvis, either alone, or before any other part. At the commencement of it, the

* See Bishop on Deformities, Lancet for 1846, vol. i.

: is observed to be out of health, emaciated, complaining of : achings in the bones, and of very great feebleness and profuse ations. Then from a fall or some other slight injury, a bone ; perhaps it unites again; but afterwards bone after bone breaks he slightest cause; the weakness increases, and the patient be- bedridden; and now, as the bones bend or break from the st influences, the chest and ribs become distorted to an almost ivable degree, and death at last occurs from exhaustion, or from stacle which the distorted limbs oppose to the action of the

The fatal issue may not occur for several years, in the vere cases. Softening of the bones of the pelvis in women is in- l by violent aching pains about the hips, and pain or difficulty king.

the *causes* of this disease, nothing is known, and of its *real nature* : little. It is evidently, however, not a *mere atrophy*. The ex- vascularity of the bones in the earlier stages of the affection, e severe pain, render it probable that they are the seat of some d cell-growth. That the urine is loaded with phosphate of lime, in a case related by Mr. Solly formed a renal calculus, is an sting and intelligible point in the history of the disease. No ble *treatment* is known, beyond common measures for supporting rength and allaying pain.*

SECTION III.—NEURALGIA IN BONE.

: bones, like other parts, are subject to that severe and continuous hich is known by the name neuralgia. The patients are gene- women, the part affected the condyles of the femur, or the head : tibia or humerus. The characters which distinguish neuralgic ave been already briefly described (p. 20), and will be further l of in the Chapter on Diseases of the Nerves.

ON IV.—INFLAMMATION AND SUPPURATION OF BONE AND PERIOSTEUM.

INFLAMMATION produces in bone the same changes that it does : soft parts. In its slighter degrees it causes softening and swell- om enlargement of the channels which contain the blood-vessels, om an opening out and greater porosity of the texture. This e followed, in protracted chronic inflammations, by the filling up expanded channels of the enlarged bone, so that, instead of being ed and porous, it is enlarged and denser than natural. They elight in hard words, may employ the term *osteoporosis* for the r, and *osteosclerosis* for the latter of these conditions. Severer s of inflammation may cause suppuration, softening, ulceration, ortification. The enlargements produced by gout and rheuma-

* a remarkable case of softness of the bones, by Mr. H. Thompson, Med. d Injuries, vol. v. 1776 (the urine deposited a copious mortar-like sedi- Solly, Med. Chir. Trans. vol. xxvii.; Paget's Lectures, i. 135; Dr. Robt. lidwifery, p. 18; Rokitansky, vol. iii.; Wedl's Pathological Histology.

tism will be considered in the Chapter on the Joints, under th
Chronic Rheumatic Arthritis.

II. ACUTE INFLAMMATION of bone most frequently at
femur or tibia in children, and is usually attributed to col
quently affects more than one bone, but is generally confin
shafts, and does not often extend through the epiphysial cart
the articular extremities.

Symptoms.—The patient is seized with violent shivering
and with deep-seated severe pain, and great swelling of th
limb, the skin of which displays a kind of erysipelatous redne
ter soon forms, burrows among the muscles, and at last
one or several places. Sometimes the
destroyed by the violence of the cons
derangement, or sinks under the profuse
tion that follows; but more frequently
served, and the bone left in a state of *nec*
examination of cases that have proved fat
have been subjected to amputation, the
the bone is generally found separated
epiphyses, and partially or entirely separ
its periosteum; and patches of newly-for
are deposited upon its surface, and be
layers of the periosteum.

*

Treatment.—Aperient and febrifuge
with leeches and fomentations, should be a
employed at first. So soon as fluctuati
detected anywhere, a free and dependin
should be made; and it is better to do s
than too late. When a free exit is provid
matter, a bandage should be applied to p
accumulation. If the patient seem like
in spite of tonics, stimulants, and nutri
limb must be amputated.

Diffused Abscess.—In some instances t
lary tube and cancelli of the bone are fe
with pus. This is apt to happen after a
excisions, and compound fracture. S
however, it is induced by cold or bruise
a wound. It may be suspected when
bone is necrosed, including its articular e
which usually escape in common inflammation, although
perishes. The facility with which a communication can be e
between the cancellous structure and the veins of an inj
explains the frequency with which symptoms of blood-pois
deposits of pus, and the other symptoms commonly att
phlebitis, are apt to occur after injuries of the skull and of ot
—See *Pyæmia.*

* Necrosis of the humerus.

III. CHRONIC INFLAMMATION of bone is most frequently the result of some constitutional disorder, and generally attacks several bones simultaneously. It is denoted by slow enlargement, tenderness, weight, and pain, increased at nights. If caused by injury, it may lead to necrosis; but in general it produces no organic change, save irregular enlargement.

Treatment.—The general health should be improved by change of air, alteratives, and tonics, especially Plummer's pill, or hyd. c. cretâ, in small doses at night, F. 63, 64, and the iodide of potassium, with sarsaparilla. Of the iodide of potassium, Mr. Stanley observes, that it never fails to assist in the removal of inflammation from bone, especially when the periosteum or medullary membrane is involved. He is in favour of small or moderate doses, such as gr. ii.—iii. thrice daily. F. 94, &c. The local measures are, repeated leechings and fomentations, so long as there is tenderness or much pain; with Scott's ointment, F. 160, or blisters or *iodine paint* subsequently.

IV. INFLAMMATION OF THE PERIOSTEUM (or PERIOSTITIS) generally occurs on the subcutaneous aspect of thinly-covered bones; especially the tibia, ulna, clavicles, and cranium. Its chief causes are, 1st, a *syphilitic* taint, in which case it produces very painful oval swellings, called *nodes*, through an infiltration of lymph and serum into the periosteum, or between it and the bone. 2ndly. *Rheumatism*, especially in persons who have taken mercury to excess. 3rdly. *Scrofula*. In the two latter cases there is usually produced a swelling of the periosteum of the entire circumference of one or more bones. The scrofulous form attacks children, and is accompanied with remarkably little pain.

If acute or mismanaged, periostitis may lead to suppuration, and caries or exfoliation; but more frequently it causes merely a superficial deposit of bone, or an expansion of the surface of the bone. Periostitis occurring near a joint, is apt to involve the synovial membrane.

Treatment.—For the acute, leeches, fomentations, purgatives, Dover's powder at bed-time, and colchicum in doses of ℥xx. of the wine every six hours; or gr. iii. of the iodide of potassium at the same interval. If the case be of syphilitic character, it may be expedient to administer a regular course of mercury, or of the iodide of potassium, when the acute symptoms are passing off. For the chronic, the same

[redacted] in the chronic inflammation of bone. The severe sciatic [redacted] the application of leeches, best relieved by removal the [redacted] quent and vigorous application of the iodine paint is my [redacted] relieving the pain and arresting absorption of the abscess, [redacted] resulting from bone, tuberculous, syphilitic, or scrofulous. As [redacted] a suspicion necessary if there is a collection of fluid between [redacted] periosteum and bone, and no measure succeed in producing its absorption [redacted] very often happens, especially [redacted] personally administered to cases [redacted] ils, and tinctures, will accomplish [redacted] cases, effected by passing a long [redacted] stance of an inch or two into the [redacted] and tension, and disorganizing [redacted] other remedies have failed. The [redacted] ve and constitutional treatment [redacted] ess is a rare consequence of in- [redacted] of the bone. A cavity lined with a vascular membrane, and filled with [redacted] pus, is formed in the substance of a bone, generally the tibia, which may or may not be externally dense around it. There may usually be a small piece of necrosed bone contained in the cavity, or some of that yellow caseous [redacted] called "cheesy tubercle." Abscess may be suspected when, in addition to permanent inflammatory enlargement and [redacted] which may have lasted for years, there is a [redacted] severe pain at one particular [redacted] aggravated at night, and unrelieved by [redacted] remedy, though perhaps it may have [redacted] temporarily. The two affections [redacted] are most likely to be confounded with [redacted] are syphilis and chronic inflammation.

Treatment. — When there is good reason [redacted] existence of abscess, the bone must be laid bare by an [redacted] I incision, and an opening be made with a trephine at the precise [redacted] of the part. Mr. S. Cooper recommends the trephine to be very [redacted] so that more than one perforation can be made, if needful; and [redacted] he shows that the operation may be resorted to with benefit, not [redacted] in cases of abscess, but in many others, in which the bone is exhibiting [redacted] unhealthy action, and its interior contains the residue of previous [redacted] disease. After the pus is evacuated, the wound must be left to granulate and contract."

[redacted] Lee's Pathological M

SECTION V.—NECROSIS AND EXFOLIATION.

The term necrosis, although signifying the death or mortification of bone generally, is yet usually restricted to one form, in which part of the shaft of a cylindrical bone dies, directly from injury, or else from violent inflammation, and is enclosed in a case of new bone. The term *exfoliation* signifies necrosis of a thin superficial layer, which is not encased in any shell of new bone.

I. NECROSIS is a frequent consequence of inflammation of the shafts of long bones in children, especially of the femur and tibia. It more frequently attacks bones or parts of bones of compact tissue, than of spongy. Yet sometimes a small portion of the cancellous tissue in the centre of the head of a long bone, as of the femur or tibia, becomes necrosed, with great detriment to the neighbouring joint. Necrosis of the lower jaw from the fumes of lucifer matches, will be noticed in the Chapter on Diseases of the Face and Mouth.

Pathology.—The bone dies; but its periosteum and the surrounding cellular tissue, if healthy, together with the articular extremities of the bone, and its medullary membrane —any contiguous healthy parts in fact — effuse lymph, which speedily ossifies, forming a new shell around the dead portion, and adhering to the living bone above and below it. The dead portion (technically called the *sequestrum*) generally consists of the circumference of the shaft only, and not of the entire thickness; for the interior of the shaft seems to be atrophied and absorbed after the death of the exterior. The inside of the sequestrum is usually rough, as if worm-eaten by the absorbing action of contiguous granulations. In the majority of cases the *epiphyses*, or articular extremities, are fortunately unaffected. After a time, if the *sequestrum* is removed by art or accident, the newly-formed shell contracts, its cavity is abolished, and it gradually assumes the shape and function of the former bone.

Symptoms of Necrosis.—After acute inflammation, the bone remains permanently swelled; and the apertures which were made for the discharge of matter remain as sinuses, from which many sensitive, irritable granulations shoot. These sinuous apertures in the skin correspond to holes in the shell of new bone (technically called *cloacæ*). They usually form above and below the *sequestrum*, or enclosed portion of dead bone; and if a probe be passed into them, the *sequestrum* may be felt loose

* Necrosis of shaft of tibia; partial formation of new bone; following upon previous caries of the head of the bone. From St. Mary's Hospital Museum.

in the interior; or at least the probe will strike against dead bone, which may be a long time separating itself from the living.

Treatment.—The indication is to remove the *sequestrum*. Any hope of its being absorbed or extruded by any natural process, is quite nugatory; and to permit it to remain, is but to condemn the patient to a perpetuance of disease and deformity. So soon, therefore, as

the shell of new bone is sufficiently strong, and the old sufficiently loose, the latter should be removed. If small, it may perhaps be grasped and removed without difficulty; if larger, an operation will be necessary. A free incision should be made so as to expose the

surface of the bone, and it should be made at a part where cloacæ exist, or where the bone is nearest the skin. Then the new shell must be perforated with the trephine, or with Hey's saw; or the cloacæ may be enlarged with bone forceps, or with a chisel or gouge; —and the sequestrum must be drawn out. If it cannot be extracted entire, it should be divided with a cutting forceps, and each portion be extracted separately. If the sequestrum cannot easily be extracted, the wound should be plugged with lint, which will tend to enlarge the cloacæ. Mr. Stanley directs that as little as possible of the new bony shell should be removed, because it might not be replaced, and the bone be left too weak to be useful. Necrosis of the articular extremities of bones, or of the tarsus or carpus, often causes irreparable disease of the neighbouring joints, and requires excision or amputation. Yet, even here, conservatism should prevail, if possible; and free incisions for the discharge of pus and debris, and for the extraction of dead or carious portions of bone should be resorted to, before a part is condemned.

II. EXFOLIATION signifies the mortification and

* The upper shows a gouge; the lower a useful form of forceps for seizing and extracting the sequestrum.

† This cut shows the extremity of the phalanx in the act of separation by exfoliation. At the part where the separation is to occur, the cancelli are seen to be enlarged, so as to form a kind of *diploë*, and their walls are thin.

exfoliation of a superficial layer of bone, or of the extremity of a bone in a joint, for example, or of the end of a bone after amputation —without the formation of a shell of new bone, as in necrosis. It is usually caused by some mechanical or chemical injury, or by stripping of the periosteum. Not, however, that stripping off the periosteum is invariably followed by exfoliation; for the bone may remain red and moist, and throw out granulations; whereas, if it be about to exfoliate, it becomes white and dry.

Treatment.—A lotion of weak nitric acid may be useful; and the exfoliating portion should be removed as soon as it can be detached.

SECTION VI.—CARIES.

CARIES is an unhealthy inflammation, through which the cavities of bone become the seat of various exudations, which interfere with the vitality of the bone substance, and cause it to be absorbed, or else to ulcerate. On examination the bone is soft and dark red; its cells are filled with a red serous or thick glairy fluid, or with soft granulations of feeble vitality, part of which may die and be converted into "cheesy tubercle."—(See p. 92.) After a time suppuration occurs; an abscess breaks, and the carious portion of the bone, already softened and spongy, gradually perishes in minute scales, which are thrown off and discharged with the pus. The bone, when macerated and dried, looks soft and spongy; eaten into hollows, and thrown into irregular elevations; the latter marking the site of granulations, and of attempts at reparation.

Symptoms.—"The external character of the limb," says Mayo, "is the same in necrosis and caries. The bone appears enlarged, and one or more sinuses open from it at points that are soft, and red, and sunken." If a probe is passed into these, it will readily break down the softened texture of the carious bone, which yields a gritty feel.

Causes.—Caries most frequently attacks bones of a soft, spongy texture; such as the vertebræ, the round and flat bones, and the articular extremities of long bones. Its genuine cause is some constitutional disorder, scrofula, syphilis, or mercury.

Treatment.—The indications are twofold; —to rectify constitutional disorder, and to remove the local disease. The former object must be accomplished by change of air, tonics, and alteratives, sea air and sea water, and the measures that

have been directed for scrofula, or for tertiary syphilis, supposing the caries to be connected with either of those maladies.

If it can be done, the best local remedy consists in freely exposing and removing the whole of the diseased portion of bone by the saw, or gouge, or trephine. If this cannot be done, lotions of the dilute nitric or phosphoric acid may be tried, injected into the sinuses with a glass syringe. Pressure by means of adhesive plaster spread on wash leather applied upon the intervals between the sinuses is often beneficial, as also is iodine paint to those parts of the surface which are unbroken and uninflamed. The latter treatment is very applicable to slow chronic debilitated cases.

But we must add that the English surgeon would do well to adopt M. Chassaignac's *drainage tube* in many cases. Any number of these may be passed through a carious bone, or in the close vicinity; as when an unhealthy abscess forms under the periosteum. By its means, the pus and particles of perishing bone are removed incessantly as they are formed, and the tissues being thus relieved of dead elements are put into a condition favourable for repair. The writer, during a visit to the Lariboisière Hospital in Paris in 1863, saw enough to convince him of the value of the *drainage* in scrofulous disease of bone.

SECTION VII.—TUMOURS IN BONE.

We have already described the various enlargements of bone, which depend on hypertrophy and inflammation. Besides these, bone is liable to every variety of tumour, and especially to enchondroma, and the fibrous, and fibro-plastic, which may respectively be developed on its surface, or within its substance. We must refer to the Chapter on Tumours for a description of these growths in general; and to that on the Jaws, for further researches on their special characters. Besides these, the following tumours require notice:—

I. TUMOURS FROM EXTRAVASATED BLOOD.—Mr. Travers * describes a case in which, after a blow, the clavicle enlarged into a firm, oval, elastic tumour; which, when punctured by a grooved needle, yielded a few drops of dark grumous blood. The whole bone was extirpated. On examination, it was proved that the tumour had evidently originated in a rupture of the vessels of the bone, and an extravasation of blood into the cancelli. By the pressure of this blood, and a continuance of the extravasation, the bony tissue was expanded and absorbed; and the cancelli were converted into chambers filled with dark solid coagula. The tumour was invested by the periosteum. The *cephalhæmatoma* of newly-born children is a state depending on effusion of blood within and around the bones of the head.

II. PULSATING TUMOURS are sometimes developed in bone, and may be of three kinds. 1st. Soft cancer, the circulation through which may be so energetic, that the tumour pulsates, and yields a whizzing sound like that heard in aneurisms. 2ndly. Tumours formed by the development of *erectile tissue* in the substance of a bone; and,

* Med. Chir. Trans. vol. xxi.

lastly. Tumours depending on enlargement of the osseous arteries.* To the last, the name of *osteo-aneurism* is given. The seat of the tumour is generally the extremity of one of the long bones, and frequently the tibia just below the knee. The patient complains of a sudden pain in the part. This is followed by painful swelling, and all the veins of the leg are observed to be very tense and full. After a time, the whole limb becomes dark red, and painful; and the tumour becomes distinctly pulsatory. It is generally moderately firm to the touch, and perhaps gives a slight crackling sensation, owing to the thin shell of bone covering some part of it. On examination it is found to be composed of a spongy tissue, containing convoluted vessels and cells, the latter filled with clots of blood in concentric layers: the bone of course expanded, thinned, and absorbed. This disease has also been observed in the humerus, radius, femur, and ilium. The treatment of such growths consists either in removing them by a direct operation from the cavity of the bone, or by ligature of the main artery of the limb; or, lastly, in very aggravated cases, resulting in entire removal of the thickness of the bone affected if this should be the main support of the limb in amputation or excision of the affected part of bone.

III. SIMPLE SEROUS or SYNOVIAL CYSTS, and those containing hydatids, are occasionally developed in bone; causing it to form a tumour, the diagnosis of which must be exceedingly difficult, until the part has been laid open by operation. Mr. Keate treated a case successfully by removing as much as possible of the cysts, and of the bone containing them, and applying a solution of sulphate of copper to the diseased surface.†

IV. CANCER appears to have a peculiar predilection for the bones; since not only are they the frequent seat of primary cancer, especially of soft cancer in early life, but they also frequently suffer from secondary deposits, especially during the progress of cancer of the breast. In many cases, too, the entire skeleton suffers a remarkable atrophy, all the bones becoming thin, light, and breaking from muscular exertion, or from the slightest violence. The bones most frequently affected with primary cancer, are the upper jaw, lower end of the femur, and upper end of the tibia and fibula.

Cancer differs somewhat in its progress, according as it is deposited in the interior or on the exterior of bone. In the former case it is usually found in circumscribed masses, which, as they increase, cause entire atrophy of the bone around, and reduce it to the thinnest possible shell, so that it breaks. When the cancer, on the contrary, is developed on the exterior, it causes considerable hypertrophy of the periosteum, and the surface of the bone sends out stalactitic branches into the tumour, just as it does when an enchondroma, or fibrous tumour, has a

* Stanley, Med. Chir. Trans. vol. xxviii.; Breschet, *Sur des Tumeurs Sanguines.*

† Vide Mr. Keate's case, Med. Chir. Trans. vol. x.; quoted also in Mayo's Pathology; case of hydatids growing on the tibia and causing absorption of the bone and fracture, in Wickham on Diseases of Joints. See also Med. Gaz. vol. xxx. p. 990; Rokitansky, vol. iii.

similar situation. It must be noticed that this ossification of the fibrous septa of a cancerous tumour does not constitute an *osteoid cancer*.

Of the symptoms, diagnosis, and treatment, we need not speak again here, except to say that the question of amputation or extirpation must be decided by the rules given in the Section on the Treatment of Cancer.

SECTION VIII.—FRACTURE GENERALLY.

DEFINITION.—The term *fracture* explains itself. Fracture is said to be *simple*, when there is no wound of the skin communicating with the broken part of the bone; *compound*, when there is such a wound; *transverse*, when the line of fracture lies across the limb; *oblique*, when the line of fracture slopes, so that the fractured surfaces tend to slip off each other; *comminuted*, when the bone is smashed into fragments; *complicated*, when there is laceration of artery, or other additional injury.

EXCITING CAUSES.—The exciting causes of fracture are two—mechanical violence and muscular action. Mechanical violence may be *direct* or *indirect*. It is said to be *direct*, when it produces a fracture at the part to which it is actually applied; as in the instance of fracture of the skull from a violent blow. It is said to be *indirect*, when a force is applied to two parts of a bone, which gives way between. This is exemplified in the case of fracture of the clavicle from a fall on the shoulder. The sternal end of the bone is impelled by the weight of the body, and the acromial end by the object it falls against; and the bone, acted upon by these two forces, gives way in the middle. Sometimes in children fracture is partial (*green-stick or willow fracture*), part only of the fibres breaking, and the rest bending.

The bones most commonly fractured by muscular action are the patella and olecranon; but the humerus, femur, or any other bone may give way from this cause, if preternaturally weak.

PREDISPOSING CAUSES.—There are certain circumstances which render the bones more liable than usual to be broken. These are, 1. The atrophy arising from old age, or from prolonged disuse of any limb. 2. Certain diseases, as fatty degeneration, *mollities ossium*, and *cancer*. 3. *Original conformation*; the bones of some people being exceedingly brittle, without any assignable cause.

REPAIR.—The first few days after fracture is a period of repose; little or no change taking place, except, perhaps, the effusion of small quantities of lymph and serum, and the absorption of blood that may have been extravasated. To this follows a period of exudation, in which plastic lymph is effused between, possibly around, the broken ends. To this follows a period of development, in which the lymph is converted first into fibrous tissue, and then into bone, or first into cartilage, and then into bone. The time which elapses before union is completed may vary from four to ten weeks; being so much the less, in proportion as the patient is younger and healthier, and especially if the fracture is

nicely adjusted, and kept at perfect rest. The material which unites a fractured bone fills up the medullary cavities, and renders the part quite solid at the seat of injury. The last stage in the process of repair consists in the absorption of superfluous bone, and the restoration of the medullary cavities. This may be completed in from six to twelve months.

The material by which fractures were consolidated was called, in old surgical works, *callus*. If the broken ends are accurately adjusted together, it is simply deposited between them, with very slight infiltration of the periosteum, and slight, if any, projection of *callus*.

If the ends are not accurately adjusted, the callus fills up any angular interspaces, as shown in the adjacent cut.

This cut also exhibits the formation of what is called a *provisional callus*, that is to say, a ferrule of new bone encircling both fragments for some little distance above and below, so as to splice them together firmly, before they are actually united by a *permanent callus*. It was formerly taught, that this is the regular mode in which the union of broken shafts of long bones is accomplished. But later researches have shown, that the doctrine of formation of provisional callus is generally true only in the case of animals, in whom it depends on the constant movement and disturbance to which their bones when broken are subjected; and in the human subject it is generally true only as regards the ribs, which are bones almost in perpetual motion.*

The source from which callus was exuded, was very much disputed in the last generation. Doubtless in the most favourable cases, of simple fracture nicely adjusted, and uncomplicated by inflammation, it proceeds from the bone and periosteum only. Yet any neighbouring fibrous tissue, is probably also capable of exuding a lymph or generating a cell growth which will ossify; nay, if the greater part of the shaft of a bone be removed or necrosed, the lymph yielded by the periosteum, if sufficiently preserved, may be converted into a new bone.

Experiments made on animals by M. Ollier of Lyons show conclusively that a portion of periosteum removed from all connections, except those absolutely necessary for its continued vitality, will produce bone even in most unnatural situations, such as under the skin of the back or neck.

Bones that do not unite.—The neck of the thigh-bone, the olecranon, the acromion, coracoid, and coronoid processes and the tuberosity of the os calcis, patella, and other bones invested with synovial membrane, do not

* See Mr. Lawson's case of Provisional Callus in neglected Fracture of the Femur in a child: Med. Times, 19th Feb. 1859.

reunite readily by bone. For this there are three reasons. First, there is great difficulty in keeping the broken surfaces absolutely in contact; and, secondly, at perfect rest; lastly, the contact of synovia, and the distension caused by its abundant effusion into the joint and between the broken surfaces of bone. Moreover, if portions of the skull be removed, the gap is not filled up.†

SYMPTOMS.—The symptoms of fracture are three: 1. *Deformity;* such as bending, or shortening, or twisting of the injured limb. This is judged of by the eye. 2. *Preternatural mobility.* This is ascertained by the surgeon, who firmly but gently grasps the upper end of the broken bone, and moves the lower, so as to see if one end moves independently of the other, or if any part yields on pressure. 3. *Crepitus;* a grating noise heard and felt both by patient and surgeon when the broken ends are rubbed against each other. If the broken parts are displaced, they must be drawn into their natural position, otherwise no crepitus will be detected. Of these three signs *deformity* is sometimes absent in fracture of the ribs, pelvis, and scapula; *mobility* and *crepitus* in impacted fractures, or when the bones are held firmly by muscular spasm. *Crepitus* is also prevented when the broken ends are separately imbedded in the adjacent soft tissues. All these signs are often absent in fractures of the skull, producing a simple fissure. In addition to these symptoms, there will be more or less pain, swelling, and helplessness of the injured part, startings and spasms of the muscles, and considerable subcutaneous ecchymosis.

The causes which produce displacement after fracture are three. 1. *Muscular action*, which produces various degrees of bending, shortening, or twisting, in different cases. 2. The weight of the parts below, which, for instance, causes the shoulder to sink downwards when the clavicle is broken. 3. The original violence which caused the fracture, as when the ossa nasi are driven in.

TREATMENT.—The general indications for the treatment of fracture are, to place the fragments in their natural position; and, having done so, to maintain them in perfect contact and at perfect rest till they have firmly united.

The first thing required in fractures of the lower extremities is to carry the patient to his home, or to an hospital, gently, on a litter, with both legs tied securely together at the knee and ankle, so that there may be no chance of the broken bone being thrust through the skin. A litter may be made of a couple of poles, and a sack or horsecloth.

* Fractured tibia and fibula after seven years; large callus and irregular ossification. St. Mary's Museum.

† See Paget's Lectures and Mayo's Pathology.

the bed on which the patient is to lie should be made as firm
vel as possible. The patient is to be gently laid on it, undressed,
amined. Before putting on any apparatus, a good washing will
use.

ondly, the fracture must be *reduced* or *set*; that is to say, the
parts must be adjusted in their natural positions. For this
e, the upper end of the limb must be held steadily by one
nt, while the lower is *extended*, or firmly, but gradually and
drawn in such a direction as to restore the limb to its proper
and shape; the surgeon, meanwhile, by manipulating with his
s, placing the fragments in their correct position. It is better
do this until the splints and other apparatus are made ready for
, lest redisplacement occur in the meanwhile by muscular spasm
fresh and painful adjustment rendered necessary. Chloroform
l be administered to prevent pain and spasm.

irdly, it is usual to bandage the whole of the fractured limb from
tremity. This is done for the double purpose of preventing
ng, and of confining the muscles, that they may not contract and
b the fracture.

urthly, it is necessary to use some mechanical contrivances to keep
mb of its natural length and shape, and prevent any motion at
actured part. It is usual to employ for this purpose *splints* of
, carved to the shape of the limb. But every surgeon ought to be
to construct splints out of such materials as the carpenter's shop
s. The surgeon should measure with a tape the sound limb which
ponds to the injured one, and choose splints that are long enough
t against the condyles or other projecting points at its extremities.
se must be *padded*; and pads are easily made of tow or horse-
well shaken or pulled out, and wrapped up in pieces of old linen.
he very best pads are made of old blankets, which should be cut
trips long and wide enough to line the splints; and a sufficient
er of strips should be laid on, to give the requisite softness, and
may be arranged so as to press, or not to press, exactly where the
on desires it. The splints, when ready, should be firmly bound
limb with pieces of old bandage or linen straps and buckles; and
they are properly put on, so as to keep the broken part immove-
and prevent muscular spasms, without being too tight, the
t is sure to express himself as unspeakably comforted. Instead
oden splints, it is sufficient in some cases to use pasteboard
ed in boiling water, so that it may be accurately adapted, and
allowed to dry and stiffen. A good plan used in the Belgian
tals, is to cover the broken limb with a layer of cotton wool, and,
(keeping up proper extension) to apply a bandage and cover
layers of brown paper, moistened and spread with good paste, to
cient thickness to keep up a resisting amount of stiffness. A
g pasteboard splint is thus formed accurately adapted to the
al shape of the limb while under extension.

e of the greatest improvements in the mechanical treatment of
ure, especially of the leg, is the *starched* or *gummed bandage*.

This is composed of layers of lint or old linen, or of bandages soaked in thick mucilage of starch or dextrine, or of mixture of equal parts of powdered gum arabic and precipitated chalk. These, when dry, form a remarkably light but firm support. A dry bandage should be put on first of all; then layers of wadding to fill up all hollows; then layers of bandages well soaked in starch.

But how is the starched bandage to be got off, or loosened, if too tight? In order to provide for this, a strip of stout tape should be laid lengthwise on the limb before the starched bandage is put on. By lifting up one end of this, the blunt point of a pair of scissors may be got under the bandage without wounding the skin; so that the starched bandage can be ripped up and taken off, as a complete mould; then, if damped with boiling water, it can be softened, and put on again more comfortably.

Plaster of Paris is an admirable material, from its faculty of quickly setting. The limb should first be bandaged with strips of paper: outside this, long thick layers of linen well thickened with plaster of Paris and water; extension should be kept up till it has set. Wounds may be left uncovered.

Splints may also be made of gutta-percha, softened in boiling water, moulded to the shape of the limb, and then trimmed with scissors, and hardened by cold water: by mixing the gutta-percha in a softened state with a proportion of one-fifth of the sesquioxide of iron, it is made more manageable in working, and sets sooner and harder and more resistant to heat than when in its unmixed state. Or of wire gauze, perforated zinc, and a hundred other substances, of which perhaps paper cut into strips, soaked in paste, and laid on in layers, is one of the most convenient.

We think it right also to mention the *straw splints*, made by filling a linen bag, of the size of the splint required, with unbroken wheat straw, such as is used in thatching, the straw being cut to the length of the limb, and the open end of the bag then sewn up. This is both splint and pad in one, and may often be of great service in country and military practice.*

The remaining treatment of simple fracture must be conducted on general principles. Cordials, to restore the patient from the shock of the injury; the catheter, if he cannot make water, which is common after fractures of the leg; aperients, if necessary; cold lotion, if agreeable; and leeches, very rarely, to allay excessive inflammation, must be employed at the discretion of the practitioner. But of all remedies for allaying pain and irritation, preventing spasms and starting and displacement of the bones, and enabling the patient to bear tranquilly the penance of long confinement to bed, nothing equals opium, in grain doses, once, twice, or thrice a day; given without the patient's knowledge, and mingled, if need be, with colocynth, to prevent constipation.

The apparatus and bandages must, if necessary, be loosened when

* See some remarks by Mr. Tuffnell, in Ranking's Abstract, vol. iii. p. 240.

swelling comes on, and be afterwards tightened sufficiently to keep the parts steadily in their place; and care must be taken to prevent painful pressure on any particular spot, and to rectify any displacement as soon as it may occur.

If the fingers or toes become blue or benumbed, the surgeon should remember the possibility of gangrene from too tight a bandage.

If through mismanagement, a fracture has united crookedly, the patient should be narcotized by chloroform, and the uniting or united part be bent, or even broken, if necessary, so as to restore the right shape. Such a proceeding may easily be effected before the fourth week, and the author knows cases in which it was done successfully after many months.

HABITUAL DEFORMITY must not be confounded with fracture or dislocation. When a person who has met with a fall, or other accident, is found to have a limb shortened or misshapen, the surgeon should always ask whether or not there was any deformity before the accident, lest he may fall into the ridiculous error of treating an old deformity as if it were a recent injury.

SECTION IX.—NON-UNION AND FALSE JOINT.

There are some cases in which fracture of the shafts of bones does not unite by bone. This is liable to happen:—

1st. If the fractured part is subjected to frequent motion and disturbance; in which case the effused lymph, instead of ossifying, will either be converted into bands of fibrous tissue, uniting the broken ends, or else a *false joint* will be formed; the ends of the bones being covered with synovial membrane, and surrounded with a ligamentous capsule.

2dly. The reparative processes may be deficient if the vital powers are exhausted by age and debility; or if the system is under the influence of gout, syphilis, or cancer; or if an acute disease or fever comes on; or if the part be deprived of its nervous influence. Thus Mr. Travers relates a case in which a patient had a fracture of the arm and of the leg, and likewise an injury of the back, which paralysed the lower extremities. The arm united readily enough, but the leg did not. In some cases of women, pregnant or suckling, broken bones have not united; but they more frequently do so. But yet there are some cases which it is as difficult to account for as it is to remedy.

3rdly. The ends of the bone may be separated by and imbedded in the adjoining muscular or fibrous tissues so as to prevent the close contiguity necessary for a proper union. This has sometimes occurred in non-united fractures of the thigh and upper arm bones.

TREATMENT.—There are three indications: 1st, To bind up the part in splints, or the starched bandages, or to envelop it in a mould of plaster of Paris, so as to insure perfect rest, perfect apposition, and pressure of the broken ends against each other. But, as Sir B. Brodie very justly observes, the bandage should not be put on so tightly as to impede the general circulation of the limb.

2ndly. Should this not succeed, after a fair trial of six weeks or two months, means must be adopted to excite the adhesive inflammation around the fracture. This may be done by rubbing one end of the bone roughly against the other, and breaking up any fibrous bands, and then splints should be again firmly applied for a month. If this also fail, some operation must be resorted to. 1. The surgeon may cut down on the fracture, by the *subcutaneous method*, and scarify the ends of the bones by a long narrow knife; or he may pass in a probe, or iron wire, between the broken extremities, and allow it to remain a week or ten days, after which the limb should be put up immovably in splints. 2. The fracture may be cut down upon, and one or both of the broken ends be drilled with holes, into which ivory pegs are to be firmly driven, and allowed to remain for some weeks. 3. A seton may be passed through the limb, between the fractured ends, or through the flesh close to the fracture. 4. If other measures also fail, the last resource is to cut down on the fracture, and saw or shave off the ends of the bone (sometimes it is found that a little piece of muscle is wedged between them, which must be removed); but these operations are of a most severe and dangerous character, and not to be resorted to without absolute necessity.

3rdly. Care should be taken to detect and remedy any constitutional disorder to which the want of union can be attributed. Debility must be counteracted by tonics, nutritive food, and stimulants. Mr. Fergusson relates a case of fractured thigh, in which no callus was formed for three weeks, until the patient was allowed a reasonable quantity of whiskey, to which he had been previously accustomed; and Sir B. Brodie relates similar instances. It will be worth while to administer *lime* plentifully in the form of liquor calcis with sarsaparilla, F. 84; or two ounces of lime-water may be given thrice a day, with an equal quantity of milk; or, which is better, the *phosphate of lime*, as recommended by the author, F. 201. Mercury may be given if there is a syphilitic taint; and Mr. B. Cooper gives a case of non-union in which, although the general health appeared perfectly good, mercury given to ptyalism effected a cure after the seton had failed.*

A few instances are known in which the callus, after union was completed, inflamed and became absorbed, so that the fracture was re-

* Vide Sir A. Cooper on Dislocations and Fractures, p. 368; Brodie in Med. Gaz. vol. xiii.; and cases by Kennett, Hill, Stanley, Bowman, Fergusson, Hilton, Geoghegan, Square, and others, in Ranking's Abstract, vols. x. xiv. and xvi.

united again. Leeches and blisters to the part proved effectual remedies.* A recent callus is also sometimes absorbed during fever; and this occurrence used to be common enough in the sea-scurvy.

SECTION X.—COMPOUND FRACTURE.

DEFINITION.—A fracture with a wound, which communicates with the fractured part.

CAUSES.—Fracture may be rendered compound. 1. By the same injury which broke the bone. 2. By the bone being thrust through the skin. 3. By subsequent ulceration or sloughing of the integuments.

DANGERS.—These are threefold. 1. The shock and collapse of the injury, which may prove fatal in a few hours, especially if much blood has been lost. 2. Inflammation, erysipelas, pyæmia, fever, and tetanus. 3. Hectic or typhoid fever from excessive suppuration.

QUESTION OF AMPUTATION.—In order to decide upon the necessity of this operation, the extent of the injury and the restorative powers of the patient, and the resources of the surgeon as to nurses, nourishment, &c., must be carefully considered. If the bone is very much shattered and comminuted; if the soft parts are extensively torn or bruised; if the large vessels or nerves are injured, or if the knee-joint is extensively damaged and freely exposed by a fracture extending also far into the femur or tibia; if, in particular, a large portion of the skin and soft parts have been torn away, or so injured that a large tract of it must slough; if the patient is very old, or much enfeebled, either by previous disease, or present loss of blood; if the collapse of the injury is excessive and permanent—amputation is probably requisite. See Gunshot Wounds, p. 156.

Compound Fractures of Joints should be treated as described under gunshot wounds.

Laceration of Arteries is a dangerous complication both of simple and compound fracture. It is detected by the great flow of blood, if there be a wound; and if not, by a rapid, diffused, and dark-coloured tumefaction of the limb, with coldness and want of arterial pulsation in the parts below. If it be the *femoral*, amputation will most probably be required, because the vein may have been injured also; if any other (the anterior or posterior tibial, for instance), it may be secured; provided that there is no other valid cause for amputation, and that the required incision will not too much aggravate the injury to the soft parts. But, *cæteris paribus*, this accident is always an additional reason for amputation, if there be other circumstances rendering it probably expedient.

TREATMENT.—If it be determined to save the limb, it must first be placed in a proper position, and then the fracture must be reduced. If a sharp end of bone protrude, and it cannot easily be returned or kept in its place, or if the periosteum be scraped off or injured, so that it will probably become necrosed, it should be sawn off. Any loose fragments or splinters of bone should be at once removed; and, if

* James, Address in Prov. Med. Trans. 1840.

necessary, the wound may be dilated for this purpose. If suffi
remain, they greatly aggravate the inflammation and danger of t
and may produce long-continued disease of the bone. If th
truding bone or its periosteum be not injured, and the size
wound does not permit it to be replaced, the wound may be dila
that purpose. After reduction, the great object is to close the wo
nicely as possible, so as to heal it up, and to convert the com
fracture into a simple one, and the best application is a piece
dipped in blood, collodion, or in compound tincture of be
then bandages and splints are to be used. If necessary, the
should have apertures corresponding to the wound, so that i
be dressed without disturbance to the whole limb. When sw
comes on, the bandages must be loosened, and cold be appl
agreeable. Pain and restlessness must be relieved by full do
opium; thirst by saline draughts, F. 58; and the bowels be op
if necessary, and if it can be done without disturbance. The ca
should be used, if required. But perhaps reaction is not fully
blished.—"We notice irregular action of the heart; the pulse do
rise as it should do; in the state of sympathetic fever the artery
subdilated, weak, and its beats are fluttering and uncertain; the t
is coated to a certain degree; the expression of the countenance agi
and unsteady in its direction; and the sensorium seems faltering
powers. The patient does not clearly understand his real state
usually declares that he feels well; he does not sleep much,
wandering when he does. The wound is dry, and the parts ab
assume an ashen colour, with the feel of puffiness in the parts about
For this condition brandy and beef-tea are the remedies. The
object in the subsequent treatment is to prevent the lodgment of m
by sponging and pressing it out carefully at each dressing, syri
with weak zinc lotion, and applying compresses to prevent its acc
lation, and, if required, by making depending openings for its disch
But if, notwithstanding the employment of tonics, wine, and good
the patient seems likely to sink under the discharge and irritation,
tation is the last resource.

SECTION XI.—PARTICULAR FRACTURES.

I. Fractures of the Ossa Nasi, and of the Malar Superior Maxillary Bones, may be produced by violent blo
falls on the face, or by gunshot injuries.

Treatment.—Any displacement of the fractured portions shou
rectified as soon as possible, by passing a strong probe or female c
ter up the nostril, and by manipulation with the fingers. A depr
fragment may often be conveniently raised by passing one blade
dressing forceps up the nostril, and applying the other externall
as to grasp the fragment between them. Some practitioners a
the habit of introducing tubes or plugs of oiled lint, in order to

* Vincent, op. cit. p. 127.

nents in their places; but this appears to be unnecessary, and ritating. A plug of lint, may, however, be requisite to check emorrhage. If the fracture is compound, any *loose* splinters e carefully removed. The great swelling, ecchymosis, bleed- the nose, and headache, with which this injury is followed, uire to be combated by bleeding or leeches, purgatives and ns, and spoon diet; and if collections of matter form, they e opened without delay. If there are symptoms of pressure rain, and the vomer seems depressed, it should be carefully rwards, if possible.

RACTURE OF THE LOWER JAW may be caused by violent Its most usual situation, says Mr. Vincent, is close to one of eeth. Sometimes in children (though rarely) it occurs at the is, and still more rarely at the angle, or in the ascending Or the bone may be fractured in two places, one on each side mphysis.

toms.—It is known by pain, swelling, and inability to move and irregularity of the teeth, because the anterior fragment is r drawn downwards by the muscles arising from the hyoid hilst the posterior fragment is fixed by the temporal. On the chin, whilst the hand is placed on the posterior fragment, will be felt; and the gums are lacerated and bleeding, and the the point of fracture loosened. The diagnosis of fracture of the *g ramus* will often be obscured by the great swelling. Great difficulty of motion and obscure crepitus, usually felt and heard the patient himself on account of its contiguity to the internal ugh the tempero-maxillary articulation, are the chief signs.

ment.—A piece of pasteboard, or gutta percha, cut to the shape en (*a*), softened in boiling water, be accurately fitted to the jaw, n a four-tailed bandage should ed. This is made by taking a l a half of wide roller, and tear- ard longitudinally, so as to leave ght inches in the middle, which ave a short slit in it. The chin put into this slit, and then two ds are to be tied over the crown ead, so as to fix the lower jaw the upper, and the other two are stened behind the head.* It is useful to place a thin wedge- iece of cork or gutta percha between the molar teeth on each ecially if any of the teeth at the fractured part are deficient, to insure more perfect adaptation, and to keep the incisor little apart. Sometimes a tooth falls down between the broken

dent *b* shows the pasteboard splint as applied; the longer piece applied ut, the shorter one doubled back under the chin, and its ends brought ther side.

parts; a circumstance which should be looked to, if there is much difficulty in fitting them together.

The patient for the first fortnight must be fed entirely with broth, gruel, bread-pap, &c. The cure generally occupies five or six weeks.

III. FRACTURE OF THE CLAVICLE is most frequently *situated* at the middle of the bone, and is generally *caused* by falls on the arm or shoulder, when it is usually oblique in direction; sometimes, however, by direct violence, when it is generally situated near the acromial extremity, and transverse to the axis of the bone. When fracture of the acromial end of this bone is situated between the coraco-acromial ligaments, there is very little displacement, and often little or no crepitus from impaction of the fragments; but when the fracture is external to these ligaments, the acromial extremity of the bone is apt to turn round at right angles to the sternal portion.*

Symptoms.—The patient complains of inability to lift the affected arm, and supports it at the elbow; the shoulder sinks *downwards, forwards*, and *inwards*; the distance from the acromion to the sternum is less than it is on the sound side;—and the end of the *sternal* fragment of the bone projects as though it were displaced, although it is not so in reality, but merely appears to be so, in consequence of the sinking of the shoulder and of the outer fragment.

Treatment.—The shoulder must be raised, and must be supported in a direction *upwards, backwards*, and *outwards*. The broken parts may be *reduced*, either by putting the knee between the scapulæ and drawing the shoulders backwards; or by placing the elbow close to the trunk and a little forwards, and then pushing it upwards. To support the parts during the cure, the most common apparatus is—

The *stellate, or figure-of-8 bandage*, represented in the cut (p. 261). In the first place a thick wedge-shaped pad must be put into the axilla, with the large end uppermost. Then a long roller must be passed over each shoulder alternately, and be made to cross on the back. In the next place, the arm must be confined to the side by two or three turns of

* A Treatise on Fractures in the vicinity of Joints, by Robert William Smith, M.D. &c. Dublin, 1847. A most complete and masterly work.

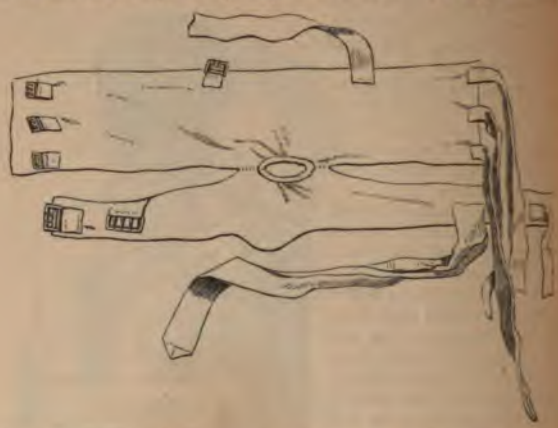
the roller; and lastly, the elbow should be well raised by a sling, which is also to support the forearm. It will be noticed, that the shoulder is kept up by the sling, out by the pad, and back by the bandage. The same objects may be gained by means of three handkerchiefs, one to act as the pad in the axilla; another for a sling; and the third to keep the arm close to the body — the whole being stitched together.

An excellent plan, of French origin, and frequently used by Professor Syme, of Edinburgh, is to take three silk handkerchiefs; two are looped round the shoulders under the axillæ, and tied behind, leaving one end of the knot longer than the other. The long ends are then passed across the back and under the opposite loop, and finally tied together, drawing forcibly the shoulders backward towards each other. The third is used as an elbow-sling to support the arm and bind it to the side.

Another simple contrivance, invented by Mr. James Duncan, for the same purpose, is a strip of *jean* about a yard long, of the shape represented in the next figure (p. 262). The elbow is fixed in the hole; the smaller straps pass back and front of the chest, and are buckled over the opposite shoulder; and the broad part is buckled round the chest, confining the arm to the side. The whole being in one piece cannot slip, and is very available for children. In ordinary cases the patient may be allowed to walk about in a week or ten days, and the cure will be completed in a month or five weeks. The patient should be informed that some little irregularity is apt to remain. If, however, there is any difficulty in maintaining a proper position, the patient must be confined to bed, and some additional apparatus be employed. The simplest is a straight splint across the shoulders, to which they are to be bound by the figure-of-8 bandage; or a splint shaped like a T, of which the horizontal part is bound to the shoulders; and the vertical part passes down the back, and is confined by a belt round the abdomen.

Besides these there is the *clavicle bandage*, which consists of two

loops for the shoulders, attached to two pads resting on the scapulæ, which are drawn together by straps and buckles.* The application of



the proper sling in these cases is very important, and its neglect or inefficiency frequently produces a contorted union of the broken collar-bone. Mr. Wood, of King's College Hospital, recommends its application in the following way:—A stout silk handkerchief long enough for the purpose is folded cornerwise and laid over the elbow and forearm with the double corner towards the hand. One end of the handkerchief is then carried obliquely along the back to the opposite shoulder, and the other across the chest to meet it; the ends are then crossed over the opposite shoulder, carried under the axilla, and tied behind. The double corner is then carried between the hand and the breast, and fastened by a needle and thread securely to the upper part of the front end near the shoulder. The hand is thus kept well up towards the opposite shoulder, the elbow well forward, and the whole arm confined effectively to the side.

In cases of willow fracture of the collar-bone in children, the proper application of such a sling is the only means of retention that is necessary or effective.

IV. FRACTURES OF THE SCAPULA.—The *body* of this bone may be broken across by great *direct* violence. One case is known also in which it was fractured by muscular action.† The symptoms are, great pain

* Mr. Vincent treats all fractures and dislocations of the clavicle by merely placing the patients on flat beds, by which the parts assume and preserve their natural position. Bandages, he says, do little good commonly, and are not required if the patient keeps his bed. Op. cit.

† Quoted in Ranking's Abstract, vol. ii. p. 104.

in moving the shoulder, and *crepitus;* which may be detected by placing one hand on the acromion or spinous process, and moving the shoulder or the inferior angle with the other.

Treatment.—A roller must be passed round the trunk over a large flat pad or napkin placed upon the scapula, and a few turns be made round the humerus, so as to fix the arm to the side, and prevent all motion. Opium and quietude, perhaps purging and low diet, will be required to avert inflammation of the chest.

FRACTURE OF THE NECK OF THE SCAPULA, by which is meant an oblique fracture, detaching the coracoid process and glenoid cavity from the rest of the bone, is a rare accident, insomuch that some surgeons have doubted its existence.*

The *symptoms* described by Sir Astley Cooper are the following:—The shoulder appears sunk, and the arm lengthened; the acromion is usually prominent, and the deltoid dragged down and flattened; the head of the humerus can be felt in the axilla; and on placing one hand or one ear on the acromion, and moving the shoulder, crepitus may be detected. Crepitus may also be felt on pressing the coracoid process, which is situated deep below the clavicle, between the margins of the pectoral and deltoid muscles. The accidents with which this fracture is most likely to be confounded are fracture of the neck of the humerus, and dislocation of the shoulder joint; the symptoms of which should be carefully studied and compared. The existence of crepitus, and the fact that the surgeon can move the shoulder freely (although with great pain), are the chief points of diagnosis between this accident and dislocation.

Treatment.—The shoulder must be supported by the same sling, bandage, and pad that are used for fracture of the clavicle; but a short sling from the axilla of the injured side to the opposite shoulder should be used in addition to the long sling from the elbow to the shoulder. Union may occur in seven weeks. Opium, rest in bed, and warm fomentations; perhaps, leeches and purgatives, will be necessary for the contusion with which this fracture is accompanied.

FRACTURE OF THE ACROMION is known by a flattening of the shoulder, because the fractured portion is drawn down by the deltoid; and by an evident inequality felt in tracing the spine of the scapula, with total inability to raise the arm outwards. It may be distinguished from any dislocation, by noticing that the humerus may be freely moved in any direction, and that, on slightly raising the shoulder, the fragment is restored to its place. This is also a rare accident; and Mr. Fergusson believes that, in some of the supposed cases of ligamentous union, the detached portion was never united by ossification to the rest of the bone from birth.

Treatment.—The same bandages, &c., are to be applied as for fracture of the clavicle; but great care must be taken to raise the elbow

* See a case by Mr. May, of Reading, Med. Gaz., 8th Oct. 1842. Mr. Wormald possesses a specimen, of which many casts have been taken by Mr. Willmott, of St. Mary's Hospital Museum.

thoroughly, so that the head of the humerus may be lifted up against the acromion, and keep it in its place. Moreover, no pad must be placed in the axilla; otherwise the broken part will be pushed outwards too much. Mr. Wood employs a broad figure-of-8 bandage, the upper loop of which passes under the opposite axilla, crossing over a pad placed on the broken part of the shoulder, while the lower loop passes down the back and under the elbow, flexed at a right angle across the chest. Three or four of the concluding turns of the bandage are to be taken round the body, arm, and hand horizontally. Union is almost always ligamentous, owing to the difficulty of keeping the parts in strict apposition.

FRACTURE OF THE CORACOID PROCESS is a rare accident, caused by sharp blows on the front of the shoulder.

Symptoms.—The patient is unable to execute the motions performed by the biceps and coracobrachialis; that is, to bring the arm upwards and forwards; and motion and crepitus of the detached process may be felt by pressing with the finger between the pectoralis major and deltoid, whilst the patient coughs or moves his shoulder.

Treatment.—The humerus must be brought forwards and inwards, so as to relax the biceps and coracobrachialis, and must be confined to the trunk.

V. FRACTURES OF THE HUMERUS.— *Fracture of the shaft* will be known at a glance by the limb being bent, shortened, and helpless, and by the crepitus felt when it is handled.

THE UPPER EXTREMITY OF THE HUMERUS may be fractured, 1, through the anatomical neck; 2, through the line of junction of the epiphysis; 3, through the surgical neck; 4, the greater tuberosity may be broken off; 5, the head may be dislocated from the glenoid cavity, and the cervix be fractured likewise.

(1.) Fracture *through the anatomical neck*, that is to say, within the capsular ligament, is a rare accident, difficult of diagnosis; there being scarcely any displacement: "The impairment of the motions of the joint and crepitus," says Dr. Smith, "are almost the only symptoms on which we can depend." There is one variety of this fracture in which the detached head of the bone is driven forcibly into and impacted in the reticular tissue of the head of the shaft, between the tubercles, one or other of which is usually broken off. "In this accident," says Dr. Smith, "the arm is slightly shortened, the acromion process projects more than natural, and the shoulder has lost, to a certain extent, its rounded form; the upper extremity of the shaft of the humerus is approximated to the acromion, and the entire of the globular head of the bone cannot be felt. In consequence

* This cut shows the line of fracture of the anatomical neck; and the line of junction of the epiphysis.

nd direct violence. *Symptoms.*—The head of the bone can
the glenoid cavity (by which sign this accident is distin-
om dislocation); it remains motionless when the elbow is
ere is a striking and abrupt projection situated beneath the
rocess, and caused by the upper extremity of the shaft of the
n inwards by the muscles which constitute the folds of the
may be felt rounded, smooth, and slightly convex, not with
irregular margin of ordinary fracture: a slight extension
lbow draws the broken point of the bone into its natural
it immediately projects again when the extension is discon-
e axis of the arm is directed downwards, outwards, and

acture *of the surgical neck* presents nearly the symptoms of
ing variety: the head of the bone felt in the glenoid cavity;
capable of being moved by the surgeon in all directions,
head of the bone remains motionless; the projection of the
of the shaft under the pectoralis muscle; the deformity re-
extension, but returning when the extension is discon-

s one variety of this accident in
lower fragment is driven up and
n the cancellous tissue of the head
e. This complication adds mate-
he difficulty of diagnosis, inasmuch
s slight shortening and some de-
ut yet none of the usual signs of
of fracture of the neck of the bone.
nay, however, be produced, if the
ry firmly grasp the head of the
st an assistant rotates the elbow.
acture *of the greater tuberosity* is
aused by blows or falls on the
Symptoms.—Great breadth of the
nt; slight projection of the acro-

teres minor; a deep groove can be felt between the fractured tuberosity and the head of the bone; the latter of which can be felt to move in its socket when the elbow is rotated, and the whole limb can be moved in any direction by the surgeon.

All of the preceding fractures, even including the fracture of the anatomical neck, usually unite firmly by bone; for though fracture at this part would seem likely to deprive the head of the bone of all vascular connection and means of support, yet probably some ligamentous bands, which are sufficient for the purpose, remain untorn: in cases of impaction there is no difficulty. Yet the patient should be informed that some deformity is likely to remain, and some loss of motion, though time and use will go far to restore the latter.

(5.) In *fracture of the cervix humeri, with dislocation*, the head of the bone can be felt in the axilla, if the arm be raised; and it can be felt not to move when the elbow is rotated. The arm is shortened, and the broken extremity of the shaft can be perceived to move under the acromion. In treating this peculiar form of injury, it is generally found impossible to restore the head of the bone to its place; but the broken summit of the shaft must be brought into the glenoid cavity, and there be retained by a figure-of-8 bandage, and by keeping the humerus close to the side.

Treatment of Fractured Humerus.—In all cases it is advisable that the patient be confined to bed for a week or a fortnight, and particularly if the fracture be at the upper extremity of the bone; which latter accident will probably be followed by great pain and swelling, and require leeches, fomentations or cold lotions, purgatives, and opiates. The hand and forearm must be well and evenly bandaged, to prevent œdema, and the fracture be set, by steadying the shoulder, whilst the elbow is drawn downwards. Next, a long carefully-padded hollow splint should be placed on the inner side of the limb, bearing well against the axilla and the internal condyle, a second on the outer side from the acromion to the outer condyle, and perhaps a third and fourth, shorter, of pasteboard, before and behind. These must be fastened by bands of firm webbing, buckled. Then the arm being placed easily by the side,* a firm broad band must be passed round the body, so as to confine the elbow to the side, and a sling put on, enveloping the hand and wrist only, to relieve the weight of the hand and forearm comfortably, but not to thrust up the elbow.

In all cases the surgeon should take care to have the parts well washed with soap and water before the splints are put on, and whenever they are shifted; otherwise the confined perspiration may cause an intolerable itching, which tempts the patient at night to loosen the bandages. No wise man neglects trifles.

In cases of fracture of the surgical neck above the insertion of the

* In fracture of the humerus, just below the insertion of the deltoid, that muscle is apt to make the upper fragment project; but if the surgeon take care that the limb hang easily by the side of the body, this will soon cease.—Vincent, p. 13.

se, Mr. Tyrrell was obliged to keep the arm at right angles with le, by means of a splint like the letter L upside down: and the n's ingenuity will often be taxed to devise means suited for par- cases.

the expiration of about five weeks, the patient may be allowed to the arm gently backwards and forwards, and gradually to bring use.

cture of the lower extremity of the Humerus may present many es. 1. There may be an *oblique fracture above the condyles*, usually happens to children. The radius and ulna, with the fragment, are drawn upwards and backwards as in dislocation ;

he natural appearance of the parts is restored by extension. her *condyle* may be broken off, and the fracture may or may not l into the joint. 3. There may be one fracture *between the two les*, and another separating them both *from the shaft*. All these s may be distinguished from dislocation of the elbow by noticing

Treatment.—The fore and upper arm should be bandaged, and a piece of pasteboard, gummed sheeting, or leather softened in water, should be cut to a right angle, like the letter L, so as to fit the elbow when bent, and should be applied on the inner and outer sides, and be retained by another bandage;† or an L-shaped splint, well padded and covered with oil or gutta-percha skin, be placed in front of the joint, and secured with broad straps of adhesive plaster above and below. This will allow fomentations and leeches to be applied behind to the joint, and being padded high in front of the lower fragment, gives a good fulcrum and power of extension. This splint may be made of perforated zinc, and provided with a male and female screw in front, and with a hinge at the elbow, so that passive motion may be applied in fractures near or into the joint.

VI. FRACTURES OF THE FOREARM.—*Fracture of the olecranon* may be *caused* by direct force, or by violent action of the triceps muscle.

Symptoms.—The patient easily bends his limb, but has great pain and inability in straightening it. A hollow is felt at the back of the joint, because the broken part is drawn from half an inch to two inches up the arm; but sometimes, when the ligaments are not torn through, this displacement may be very trifling, or altogether absent.

Treatment.—The patient may be allowed to move the part gently in three weeks. Union will be ligamentous, unless the parts are in the closest apposition. The French surgeons treat this injury by a flexed position of the arm with a view to the possible occurrence of anchylosis. A perfectly straight position is apt to tilt backward the upper end of the olecranon against the fossa of the humerus. The best way of treating it is to use a straight splint, and to pad it thickly opposite the joint, so as to give a slight bend, and to secure it by broad straps of adhesive plaster.

If there is much inflammation, it must be subdued by rest and leeches before any tight apparatus is put on. M. Malgaigne's hooks, p. 285, have been applied, in order to insure apposition.

Compound fracture of the olecranon is far from an uncommon consequence of violent blows or falls on the elbow; and it is often followed by protracted disease of the joint. The part must be bathed and fomented; any loose fragments of bone be extracted; the wound be closed with bloody lint, or collodion, if the skin can be neatly brought

* Line of fracture of the internal condyle.

† A very convenient angular splint is made by Matthews, and other instrument makers, capable of being adapted to various lengths and positions of limb, and useful in most cases of fracture of the arm or forearm.

; the elbow must be kept straight and motionless with a leeches and fomentations be used to reduce inflammation; and e wound is healed, and the joint free from active disease, gentle must be employed to restore it to its proper uses. If the bones ressively comminuted as to render it probable that the process ation will be tedious and exhausting, of the joint should be performed; ndeed, the injury is so very severe nder amputation indispensable.

ture of the Coronoid Process is very It is caused by the action of the bra- muscle. Mr. Liston gives a case of h occurred to a boy of eight years l was caused by his hanging with nd from the top of a high wall. sometimes attendant upon dislocation bones of the forearm backwards. In e there is much difficulty in keeping es in their proper position. A speci- such a fracture with dislocation is in seum of King's College.

ptoms.—Difficulty of bending the and dislocation of the ulna,—the n projecting backwards.

tment.—The arm must be bandaged, d at rest in the bent position. Union will be ligamentous.

tures of the shafts of the Radius and Ulna, together or singly, wn by the ordinary signs of fracture, especially by the crepitus fixing the upper end, and rotating or moving the other. The of the pronator quadratus, when freed by a fracture of the t its middle third, from the opposite and controlling action of inator brevis, almost invariably gives a prone position to the d wrist. The hand is also usually everted in this injury by the f the supinator longus upon the lower fragment. In fracture of one singly, and especially of both bones together, the lower frag- re very apt to be drawn together by the pronator quadratus, so as erate, if not corrected, the interosseous space and prevent the ng and supinating power so essential to a proper use of the The objects in the treatment are to prevent the fractured ends r bone from being pressed inwards towards the interosseous nd to prevent the upper fragment of the radius from being more *ed or everted* than the lower.

tment.—The fracture is easily reduced by extension from the d elbow. Then the elbow being bent, and the forearm placed sition intermediate between pronation and supination (that is to th the thumb uppermost), one splint should be applied to the ide, from the inner condyle of the humerus to the fingers' ends; ther from the outer condyle of the humerus to the back of the

Fracture of olecranon. Ligamentous union. St. Mary's Museum.

wrist. Both splints should be wide enough, and should be well padded along their middle, so that they may prevent the bones from being pressed together. The hand should be kept in a line with the forearm. The cure is generally complete in a month or six weeks.

Fracture of the lower extremity of the Radius, from half an inch to an inch above the wrist, is now commonly called *Colles's fracture*, from the name of the eminent surgeon who first accurately described it. It deserves careful study from its liability to be mistaken for dislocation. The carpal extremity of the bone is usually broken off either obliquely or transversely, and the fragment is drawn backwards and outwards by the extensors of the thumb and supinator longus. Of course the

carpus and metacarpus go along with it. Thus, if the back of the forearm be looked at, there is seen to be an apparent swelling, formed by the carpus and lower fragment; and immediately above this a well-marked sulcus. On the palmar side is a more extensive but less prominent swelling, which seems as if caused by the flexor tendons being thrown forward: this swelling extends about one-third up the forearm, and terminates below at the anterior annular ligaments of the wrist. The extremity of the ulna is seen projecting towards the palm and inner side of the limb; sometimes it is even dislocated forwards. The chief points of distinction between this injury and dislocation, are the facility with which all deformity is removed by grasping the hand and making extension; the return of deformity on ceasing the extension; and the position of the styloid process of the radius, which moves with the hand if the case be fracture, but not if it be dislocation.

Other varieties of fracture at this part are, 1. Oblique fracture of the posterior margin of the articular surface of the radius, with partial dislocation of the hand backwards: 2. Fracture of the lower end of the radius, with displacement forwards: 3. Fracture of both radius and ulna, which may be recognised by attention to the symptoms presented.

* This cut is copied from Dr. Smith's work on Fractures.

† Vertical fracture of lower extremity of radius. Fracture also of styloid process of ulna, with ligamentous union. From a preparation of the late Mr. Wilmott, of St. Mary's Hospital.

tment.—The elbow being bent and steadied, the hand should be and powerfully extended, and at the same time somewhat l. A pad should be placed along the extensor side of the fore- d the thickest part of it should correspond to the displaced t of the radius, against which it should press, so as to push it , and somewhat in the prone position as well. Another pad e placed on the flexor side, but should not reach lower than gin of the superior fragment. "An anterior and a posterior ays Dr. Smith, "are then applied, each of which should be at inch broader than the forearm; the posterior should extend elbow to the fingers, and should be curved from the wrist rds to receive the adducted hand; the anterior need not descend e palm of the hand; a roller is then to be carried around the n the usual manner." Three weeks should elapse for a young and four or five for an old one, before the wrist is moved; and ent should be informed at first that some months will elapse e use of the part is restored.

—FRACTURES OF THE HAND.—The *carpus* is rarely fractured so much other injury as to render amputation necessary. of the *metacarpal bones*, or of the *phalanges*, will be readily d. The former usually project forward when broken, by the rating action of the anterior muscles. With respect to com- acture of these parts we may observe, that no part of the hand e amputated unless positively necessary, and even one finger e saved if it can be done.

ment.—For fractures of the carpus, middle metacarpal bones, phalanges, it is a good plan to make the patient grasp a ball r some other soft substance, and bind his hand over it; for of the lateral metacarpal bones, it is better to support the hand wooden splint, cut into the shape of the thumb and fingers. If r only be fractured, it may be confined by a thin lath or paste- dint. It must be recollected that the palmar surfaces of the al and digital bones are concave. They must, therefore, be padded before they are bound to any flat surface, or they will olkedly.

FRACTURE OF THE RIBS is generally situated in their anterior l is commonly caused by *direct* violence, such as blows; the ing way at the point struck. Sometimes, however, it is y *indirect* violence; as, for instance, when the chest is violently ed between two points. In 1837, several people were crushed in a crowd in the Champ de Mars, in Paris, and many of them nd to have several ribs broken in this manner. Sometimes, bjects, one or more ribs are broken by violent coughing.*

ions.—Fixed lancinating pain, aggravated by inspiration, , or any other motion. By tracing the outline of the bone, or ag the hand or the stethoscope upon it, crepitus may be felt

* An interesting paper on Fracture of the Ribs, by M. Malgaigne, in the . de Méd. 1838, quoted in B. and F. Med. Rev. vol. vii. p. 554.

during the act of coughing or inspiration, and the patient is sensible of it likewise. If the fracture be situated near the spine, or if the patient be very corpulent, it may be difficult to detect it with certainty: but this is of little consequence; for in every case, when a patient complains of pain on inspiration, after a blow on the chest, the treatment is the same.

Treatment.—The indications are, 1. To *diminish motion* of all the ribs, by passing a broad flannel roller, or a towel fastened with tape round the chest, so tightly, that respiration may be performed chiefly by the diaphragm. The bandage should have shoulder-straps to keep it up. The arms should be confined to the side so as to prevent all motion of the scapula; and this latter in fat women is all that can be done: moreover, there are some patients who find all bandages intolerable, but who do very well by being kept quiet in bed. Another plan sometimes used is to apply broad straps of adhesive plaster round the side of the chest on which the fracture is placed, leaving the opposite side free. 2. To *prevent inflammation* of the chest, keep the respiration easy, and relieve pain or cough, by rest in bed, by purgatives, and opiates; bleeding if necessary.

Emphysema, a swelling caused by the presence of air in the cellular tissue, is an occasional complication of this fracture. It is produced in the following way:—The extremities of the fractured rib perforate both *pleuræ* and wound the lung. In the act of inspiration, air escapes from the lung into the cavity of the pleura, and from thence through the wound in the *pleura costalis* into the cellular tissue of the trunk. *Emphysema* forms a soft puffy tumour, that crepitates and disperses on pressure.

Treatment.—"The first object," says Mr. Vincent, "is to adapt a firm bandage over the part of the rib broken, by which the effusion of air into the cellular tissue under the integuments is stopped. The air passing from the wounded lung is now confined to the cavity of the pleura, with which it is filled, compressing the lung. By this means the wound which was made whilst the lung was dilated, is more completely closed than would have been done with any contrivance of art. This wound is usually healed on the eighth day: at that period the breathing greatly improves,"† and the case is soon reduced to one of simple broken rib.—See the Chapter on the Injuries of the Chest.

IX.—FRACTURE OF THE STERNUM. *Symptoms.*—Crepitus may be felt during inspiration or other movements of the trunk, and displacement (if any) can be detected by examination.

Treatment.—The same as for fractured ribs.

X. FRACTURES OF THE PELVIS can be caused only by most tremendous violence, so as sometimes to wrench open the sacro-iliac joints; and are often attended with some fatal complication;—such as laceration of the bladder or rectum, or of the great arteries or veins.

Treatment.—The only thing to be done is, to place the patient at perfect rest, and in as easy a position as possible; to keep a catheter in

† Vincent, op. cit., p. 47.

the bladder; to make incisions if urine is extravasated into the peritæum, as it will be if the urethra is lacerated by fractured portions of the rami of the ischium and pubes, and to treat any symptoms that may arise. If it can be borne, a broad belt may be passed round the pelvis; and another under the nates, which might be attached to a pulley over the bed, so that the patient may raise the pelvis, without exerting any of the muscles attached to it.

There are some cases of fracture of the os innominatum passing through the acetabulum, and caused by falls on the hip, which might be mistaken for fracture of the cervix femoris. For instance, in some cases related by Mr. Earle,† the foot was everted, and there was loss of prominence of the trochanter; but there was no shortening, and the limb could be turned freely outwards, which motion is highly painful after fracture of the neck of the femur. In a case reported by Dr. George D. Gibb, of Portman Street, in which the right side of the pelvis was literally smashed, the leg was everted and shortened an inch and a half; the trochanter nearer the anterior superior spinous process than on the sound side. On rotating the limb, the right trochanter appeared to move in the segment of a smaller circle than the left, and crepitus was distinctly felt in the joint. The diagnosis will be aided by the crepitus felt on applying the stethoscope to the ilium, and by examination per anum. It very rarely happens that the acetabulum and cervix femoris are both fractured. The patient must be kept on a fracture-bed. One of Mr. Earle's cases was cured in eight weeks, Dr. Gibb's in sixteen.‡

Fracture of the *os coccygis*, or of the lower extremity of the sacrum, may be caused by violent kicks or falls; the former may occur during parturition to women who have children after the coccyx is united to the sacrum. The loose portions must be replaced by introducing the finger within the rectum. The patient should keep in bed, and the bowels must be kept relaxed, so that no disturbance may be occasioned by hard stools.

XI. FRACTURES OF THE FEMUR present many varieties, which must be carefully studied; because, as Pott observes, "they so often

* Fractured pelvis. St. Mary's Museum.

† Earle on Fractures of the Pelvis, Med. Chir. Trans. vol. xix.; see also case lxxi. in the last edition of Sir A. Cooper on Fractures and Dislocations.

‡ British American Journal, Sept. 1849.

or fall the patient finds himself un
pain, increased by motion, and prin
part of the thigh. The leg is sho
outwards;—the heel rests in the
Achillis of the other leg; *crepitus*
stethoscope be placed on the troch
its proper length and rotated. W
shortens again. The trochanter ge
side; and if the foot be rotated by

* It is sometimes stated that the ne
in old persons, and sunk from the ob
doubtful whether this is the case, exce
chronic rheumatic arthritis. In this
persons, the acetabulum is expande
growths; the cartilage removed and
neck of the femur shortened so that t
of the shaft; the capsule thickened,
(which have sometimes been mistaken
a fractured cervix); sometimes at t
inserted, the bony texture is complet

segment of a lesser circle than natural. The limb may generally be freely moved by the surgeon, although with great pain, especially if it be abducted; but the patient cannot lift it from the bed.

The above symptoms are liable to considerable diversity, arising from accidental variations in the manner in which the fracture occurred. Thus (*a.*) the *amount of shortening* (which was stated by Sir A. Cooper at from one to two inches) depends on the degree to which the fibrous investment of the neck is lacerated. This investment is thickened by a reflexion of the fibres of the capsular ligament from its attachment into the neck of the bone towards the head, where it is covered by the synovial membrane of the joint. If that membrane be not much injured, the shortening may be much less than an inch; moreover, it is doubtful, according to Dr. Smith, whether the capsular ligament, if entire, would permit the limb to be drawn upwards for more than an inch. Again, if the fibrous investment of the neck be not torn, or if the fracture be very oblique, so that the upper opposes the ascent of the lower fragment, or if the lower be driven into and impacted in the upper fragment, there may be no immediate shortening at all.

(*b.*) The *time at which shortening occurs* may vary. Sometimes it is very slight at first, but becomes very decided in *a few days*, doubtless when the muscles have recovered from the paralysing effects of the injury. Sometimes, in an obscure case of fracture, the limb retains its natural length for a few days or weeks, and then *suddenly shortens*, whilst the patient is attempting to walk: doubtless because the attempt has caused the laceration of some untorn fibres of the periosteal investment of the cervix, which before held the fractured parts in apposition. In other cases the limb *gradually* shortens to the extent of one or two inches during the six months succeeding the injury. This is owing to interstitial absorption of the neck of the femur.

(*c.*) The *position of the limb* is sometimes anomalous; being inverted in a few cases.

(*d.*) In some cases the neck of the bone is driven into, and impacted firmly within, the cancellous tissue of the head; a circumstance which of course renders it difficult to say whether the injury be one of fracture or of mere contusion. The chief characters of this injury are those summed up by Dr. Smith:—"1. Slight shortening of the limb. 2. Slight eversion of the foot. 3. Absence of crepitus. 4. Great difficulty in all cases, and in the majority an impossibility of removing the shortening of the limb by extension; and, lastly, less loss of power than in other forms of fracture of the neck of the femur."

Prognosis.—This fracture does not unite by bone, except in the rare instances in which the broken surfaces are held closely together by the untorn periosteum, or by impaction; or in which the fracture is partly internal and partly external to the capsular ligament. In such cases there is no doubt that bony union may occur; but in the majority the fracture either unites by ligament, or, more commonly, does not unite at all; but the stump of the cervix becomes rapidly absorbed, rounded, and covered with a smooth porcellaneous deposit, and plays in a socket formed by the hollowing and absorption of the head. The capsular ligament becomes excessively thick, and so does the obturator externus muscle, so as to support the weight of the body. The reason of this non-union is, probably, the want of apposition and of pressure of the fractured surfaces against each other; to which may be added the age and debility of the patients; the atrophy of the part injured; the imperfect nourishment of the upper fragment, and the general indisposition of bones covered with synovial membrane to throw out callus.

Diagnosis.—The surgeon should be aware that a fall on the hip is apt to produce interstitial absorption and shortening of the neck of the femur, with disappearance of the cartilage, eburnation of the articular surfaces, and irregular deposit of bone around the cervix (the same series of changes which the part undergoes in chronic rheumatic arthritis), with shortening of the limb, and wasting of the muscles; with most of the conditions, in fact, that follow a fracture. Thus, the patient on recovering from the immediate effects of the injury, finding the limb lame and shortened, may accuse the surgeon of having overlooked a dislocation or fracture. Of course the surgeon must defend himself by proving the absence of the symptoms of these injuries immediately after the accident, and by reference to authenticated

* Impacted fracture of neck of femur. St. Mary's Museum.

cases in which the same ill consequences have followed bruises without fracture.*

Treatment.—If the patient is very old and feeble, it is of no use to sacrifice his little remnant of health and strength, and run the risk of producing sloughing of the nates by long confinement to bed, in the hope of procuring union by bone. But he should be kept in bed for a fortnight, till pain and tenderness abate; with one pillow under the whole length of the limb, and another rolled up and placed under the knee, or he may be placed on a fracture bed. Then he may get up and sit in a high chair, and shortly begin to crawl about with crutches; and in time he will regain a tolerable use of the limb, especially if not very corpulent. The sole of the shoe must be made thick enough to counteract the shortness of the limb. It must be added, that this injury often proves fatal during the first three weeks from the shock to the constitution, or from the bruises inflicted on the limb.

(2.) *Fracture external to the capsular ligament* is caused by direct violence, such as falls or blows on the hip, by which the neck of the femur is broken off, and driven into the cancellous structure of the great trochanter; and at the same time one or both trochanters are split through likewise. If the cervix be firmly impacted, and the trochanters are still adhering by untorn periosteum, the diagnosis of this fracture presents obvious difficulties, for there is no crepitus; the limb is shortened, but yet cannot be brought to its natural length by any justifiable amount of extension, and is not so everted nor so powerless as is usual in fracture; yet if the distance of the trochanter from the anterior superior iliac spine be measured, it will be found less than on the opposite side: the projection of the trochanter is also somewhat diminished. If, however, this fracture be so comminuted, that the cervix is not impacted in the shaft, the shortening and eversion are well marked, and crepitus can be produced on extension and rotation.

(3.) *Oblique fracture through the Great Trochanter.*—This accident may occur at any period of life, and is attended with the following symptoms:—the limb is everted, but very little shortened, and the shaft of the bone may be felt widely separated from the trochanter. This fracture unites readily by bone; and the treatment required con-

* Smith, op. cit.; Canton, on Interstitial Absorption of the Neck of the Femur from Bruise, &c. Med. Gaz., Aug. 11, 1848.

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reach from below the axilla to four or

upper end it has two holes, and at

First, the splint should be thoroughly well padded with layers of blanket. Then the limb should be evenly bandaged from the toes upwards, and gently extended to its proper length and shape. Next, one fixed point of extension is made by passing a bandage repeatedly round the instep and ankle, and through the notches at the lower end of the splint. Next, the splint is thoroughly secured to the limb by a bandage carried upwards. Lastly, the extension is to be made by grasping the foot and splint together, and steadily making traction, while an assistant draws up tightly the perineal band through the holes at the top of the splint. This method of not attempting extension till after the ankle is secured to the splint is a saving of much pain to the patient.

The next cut shows an improved form of the long splint, employed by Mr. Haynes Walton. It will be seen that it does not extend below

the foot, and that it has two splits of unequal depth, through which the bandage is passed, so as to get a thorough purchase from the a kle

(not from the heel and dorsum of the foot), and to keep the splint square with the leg. The ankle should be well padded. For a perineal band, Mr. Walton recommends a fold or two of blanket, or several folds of flannel, sewed up in oiled-silk, and having a piece of stout tape tacked to each end.

In order to prevent the galling of the perineal band, and its supposed tendency to draw the fractured parts asunder, Mr. Fergusson had adopted the plan in some cases of making counter extension from a strong stay of jean, accurately fitted to the upper third of the opposite thigh; from which a band extends back and front to the upper end of the splint. This is very comfortable, and obviates the necessity of the band round the belly, since it draws the splint *towards* the body.

Professor Syme of Edinburgh now treats fractured thigh-bone by placing the patient straight upon a hard mattress, drawing over both legs and body a folded bedsheet, which is then fastened down at the sides. Along each side of the fractured limb, long sandbags are then

placed reaching from hip to heel. The feet are not included under the sheet, but kept in a symmetrical position with each other.

In the United States, this injury has lately been much treated upon a plan of Dr. Nathan Smith's. This consists in placing along the front of the limb from the pelvis to the toe a piece of iron wire, of the thickness of a No. 10 or 12 catheter. This is bent at the knee and

ankle joints into an easy angle and fastened to the limb, without being permitted to touch it, by adhesive plaster and a roller, omitting an interval if there be any wound. The wire and limb are then suspended to the ceiling of the room by a hook and cord, the latter being fastened to the wire in two places, one above another below the knee. Extension is made by the degree of obliquity given to the suspending cord, and counter-extension by raising the foot of the bed on bricks, so that the inert gravity of the trunk tends towards the head in the opposite direction.

Mr. Fergusson has devised a modification of the straight splint, consisting of a long iron bar, of the length of the ordinary straight splint; the upper half of which can be unscrewed and removed, so as to make

it a short splint, for fracture below the knee. It has a foot-board, which can be adapted to any length or thickness of limb, and to any portion of the knee or ankle-joint.*

2. A second plan is that of Pott.† It consists in laying the patient on the affected side, the thigh at right angles to the trunk, and the knee bent—with a many-tailed bandage and four splints, applied between the pelvis and trochanter above, and the knee below. The disadvantages of this plan are, first, that the patient soon turns round on his back, dragging the upper fragment away from its right place; and, secondly, that the pressure on the great trochanter may cause sloughing. The first evil may be prevented simply by watching the patient, and telling him to turn round on his belly rather than on his back, if he wishes to shift his position. The second may be remedied by placing him on his back, at the end of a fortnight, with his knees bent up, and supported by pillows.

3. A third plan of treatment is by the *fracture-bed*, of which the best modification is that of Mr. Torry Hester, of Oxford. The patient is placed on his back; the thigh and knee bent up over a double inclined plane, in which position they are kept immoveably. But the whole bed is placed on a sort of hinge, so that the patient's trunk can be raised or lowered, without causing any motion of the hip-joint.‡

4. The starched bandage may be employed in fracture of the lower third.

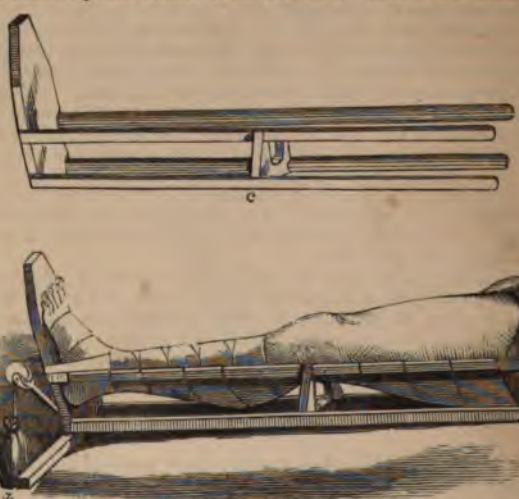
Another plan, which enables compound and gun-shot fracture of the femur to be easily dressed, when the wound is on the hinder part of the limb, has been devised by Surgeon John T. Hodgen, of St. Louis, U. S. A cradle is constructed, of the accompanying figure (p. 282). The foot-board, *a*, is 4½ inches wide, 1 inch thick, and 14 inches long, and rests on a tranverse rod, *a*, 15 inches long and 1 inch square. The centre support, *c*, is 7 inches high, 8 broad, and 1 inch thick. This piece is 21 inches from the footboard. The longitudinal strips are 42 inches long, 1½ inch wide, and ½ inch thick; each is screwed at one end to the footpiece, leaving 4½ inches between the upper and lower. The lower are fastened to the outside of the centre support at *c*; the upper, at the inner side of the upright portion. It is adapted to either limb by binding the ends of the pieces designed for the perinæum and pubes, and shortening them, so that the foot may come to the footboard;—the upper strip passing in front of the pubes, the lower, a short distance from the perinæum. Strips of cloth 2½ inches wide are now placed on the upper longitudinal bars and pinned, so that they may form a double inclined plane, on which the limb may rest. Any one or more of these may be removed or renewed when necessary for cleanliness' sake. Broad strips of adhesive plaster are now placed on either side of the leg, and

* Many forms and varieties of this splint are manufactured by Matthews, of Portugal Street, Weiss, and Savigny.

† Pott, Chirurgical Works, vol. i. p. 365.

‡ A New Method of managing Fractures, by James Torry Hester, 1853.

secured with a roller. It is now placed on the plane, and the free ends of adhesive plaster secured to the footboard. Extension is maintained,



by a weight and pulley. The bottom legs of the bedstead are raised upon bricks, so as to make the weight of the trunk the counter-extending force. Thus the limb is suspended; air freely passes round it; its circulation is not impeded; there is no sore heel, nor perinæum; the bed-pan can be used, and the wound dressed, or any displacement rectified without disturbance.*

If *both thighs* are broken, a fracture-bed may be employed, if the surgeon has one.

(7.) *Fracture of the Condyle into the knee-joint* mostly happens to old persons, and not unfrequently proves fatal. In these cases the leg should be placed in as straight a position as possible in anticipation of some degree of anchylosis of the joint.

XII.—FRACTURE OF THE PATELLA may be of two kinds, according as it is caused, (1,) by muscular action, or (2,) by direct violence.

1. *Fracture of the Patella by Muscular Action* generally occurs thus: A person is in danger of falling, perhaps from missing a step in going down stairs, or from missing his footing after a leap. The knee is bent, and the patella drawn up; and then a sudden contraction of the rectus snaps it across. The *symptoms* experienced by the

* Am. Med. Times, May 23, 1863.

patient are, the feeling as of a blow or sudden snap, and inability to straighten the knee. The surgeon, on examination, finds a chink between the broken parts, into which he can press his finger, and which is increased by bending the knee.

This, as we have already said, is one of the fractures in which it is very difficult to produce reunion by bone, in consequence of the difficulty of bringing the broken surfaces into exact apposition. And not only so, but even when the patient's recovery is considered complete, the fragments are apt to be left in a state of very wide separation; the power of the extensors, and, consequently, of straightening the knee, and of keeping it straight, is lessened or almost lost, and the patient is not only lame, but in constant danger of falling, and of again rupturing the connection between the fragments, or else of breaking the opposite patella.

The exact pathology of this accident has been very minutely studied by Mr. William Adams, who has shown, in the first place, that the fragments may be united by true ligamentous substance, a firm mass of new tissue, generally from half an inch to an inch long, and passing between the broken surfaces. This is represented in the diagram A (p. 284); and if the ligament is short, the cure is a good one.

But, in the second place, Mr. W. Adams has shown that in the cases in which the patient recovers with wide separation of the fragments (and in some cases this is so much as four or five inches), there is no ligamentous union at all; but the fragments are merely held together by the subcutaneous fascia in a thickened condition. So that what is commonly called union by a long ligament is in reality no union at all.

* This cut represents an old fracture of the patella, with wide separation of the fragments. The patient fractured the bone twice. The first time he was treated with bandages, &c., to bring the broken parts together, and they united well. The second time the limb was laid in an easy position without bandages. The result is here shown:—The upper fragment high up in front of the femur; the lower one down in front of the tibia; the power of extending the joint lost. When the knee is bent, as in the above cut, the condyles of the femur are seen with the skin tightly stretched over them.

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In the *treatmen*
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heel. Extension of the leg relaxes the va
the trunk relaxes the rectus femoris.

Secondly, to bring the fractured surfa
possible. In some cases, in which the lig
and by the side of the patella are not exte
separation, that no apparatus is requir
places a simple pad, or strap, or bandage
beneath the lower fragment, and draws t
straps passing between. The same end
a figure-of-8 bandage. A leather strap
limb, just above the patella, and a tape p
may be fastened to a slipper on the foot.
with a starched bandage, applied from t
thigh, and pressing *above*, but not *upon* th

A very comfortable apparatus is Wood'
This is a straight light iron splint, p
hooks behind the knee. Over these the
may be passed, including in each opposit
respectively, or a ring of vulcanized indi

and that they may pull upon the skin, and not the bone, and so do more harm than good.

In surgery, as in all other arts, those means are best which act directly; and there is no doubt but that the best instrument for treating fractured patella is M. Malgaigne's hooks, here depicted. Two of the hooks are fixed into the tendon at the upper edge of the bone, and two into the lower, and they can be brought and kept in apposition by the screw. They cannot penetrate the bone, nor wound the joint. They may be kept in six weeks, to insure bony union. Malgaigne had treated (1853) about eleven patients, producing bony union, and no bad results.*

Thirdly, inflammation must be sedulously prevented if possible. If it comes on, it must be removed by leeches, cold lotions, or warm fomentations, and purgatives; and no constricting apparatus should be applied during this condition.

In such a case as that depicted and described at p. 283, it has been proposed to scrape off the aponeurotic membrane which adheres to the broken surfaces, by subcutaneous section, and then to apply the hooks.

2. *Fracture by direct violence* is generally comminuted; perhaps longitudinal. There is

* See a very able paper in Med. Times and Gazette for 1864, vol. i. p. 86, by Mr. Pyle, of the Middlesex Hospital, for a series of eight cases treated by the hooks and eight by the old method. The superiority of results is remarkable, and not less so the less amount of irksomeness and shorter time of cure. The author believes from results which he has seen that fractured patella is one of the opprobria of English surgery.

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XIII.
—The
may be
ful exa
methods

(1.) *By the common splints.*—The injur
side, the fracture is reduced by extensio

Then a many-tailed bandage is applied
manner represented in the cut. This band
take a piece of roller, long enough to reach
and to overlap about one-third of the leg b
into pieces, and lay them across the first

limb; another to the inner side; and if there is any projection of either fragment, it should be kept in its place by a third slight splint to the shin. The outer splint should have a foot-piece, which should be carefully padded in such a manner as to prevent the foot from turning either inwards or outwards, especially the latter. There is a very useful rule, which should be attended to in all cases of injury below the knee; it is, *to keep the great toe in a line with the inner edge of the patella.*

(2.) By the Macintyre's leg splint, or some of the numberless varieties of it in existence, as improved by Mr. Liston and other sur-

geons. The adjoining cut represents it as applied to a patient of Mr. Fergusson's in the King's College Hospital, with a compound fracture, which is left uncovered by the bandages. It is straightened out by means of the screw under the knee, as Mr. Fergusson prefers the straight position in almost all cases of fracture of the lower extremity. Before its application, it must be made to correspond to the length of the sound limb, and must be well padded.

(3.) By the very convenient *side-splint* of Mr. Fergusson's, described in a preceding page. This may be applied either on the inner or outer side, according to circumstances.

(4.) By the *junks.*—This very simple but efficient contrivance consists of a piece of old sheeting, with a bundle of reeds rolled together from either end. But it is more easy to comprehend it from seeing it once than from a page of description.

(5.) *By the starched or plaster of Paris bandage.*—In simple cases of fracture of the leg, the patient may leave his bed at the end of a week, with the fracture supported by the starched apparatus. When this has become dry, the patient may get up, and move to his chair or sofa with crutches, but the foot must be suspended from his neck by a sling; and he must be particularly cautioned not to attempt to move it by his own efforts.

(6.) In the United States fractures of the leg are usually treated by Dr. Buck's method. This consists, first, in placing on each side of the

sirable.

Lastly. In all cases of fracture o
pend, or swing the injured part,
similar apparatus. It is not only
but it allows of the use of the be
turbing the fracture.*

For FRACTURE OF THE HEAD O
JOINT the treatment is the same as
femur. The limb should be place
femur may act as a splint, and kee
The whole limb should be raised, so
the knee; and this should be done i
end of the tibia (for which, conseq
with the knee bent, is inapplicable).
bandages should be applied to ke
should not cover the front of the
commenced in about five weeks.

FRACTURE OF THE LOWER END O
above the ankle joint (Potts' fracture
and may be caused by twists of the f
ing on uneven ground.

FRACTURE OF THE INTERNAL M
way; and one or the other of these

with Dupuytren's (p. 288), which is a diminutive of the long straight splint. It is to be well padded, and applied to the side opposite the fracture; but it is not so easy to keep the foot in a proper position with this as with the other apparatus.

The surgeon will often find one or more *bags of sand* most convenient auxiliaries in keeping fractures of the leg in proper position. They may be used both to lay the broken limb upon, and also to put on either side to prevent the limb from rolling. This substance is so ponderous and devoid of elasticity, that it steadily retains whatever position is given to it.

Compound fractures of the leg are to be treated on the principles already laid down for the treatment of compound fracture in general. Some cases do very well laid on the outer side on a well-padded side-splint, and covered by a many-tailed bandage. This position is most suitable for cases complicated with erysipelas, sloughing, or burrowing of matter, along the front and inside of the limb.

XIV. FRACTURES OF THE FOOT will often be attended with so much other mischief as to render amputation expedient. But an attempt should be made to save part of it; especially the ball of the great toe. Pasteboard splints and other contrivances must be used to preserve the proper position; and if matter forms, there should be no delay in freely dividing the dense fasciæ of the foot, to let it escape.

The tuberosity of the os calcis may be broken by the action of the muscles attached to it, in the same manner as the patella and olecranon, and like these parts will probably unite only by ligament. The treatment must be the same as that of ruptured tendo Achillis.*

CHAPTER VI.

DISEASES AND INJURIES OF THE JOINTS.

SECTION I.—THE SYNOVIAL MEMBRANE.

1. ACUTE INFLAMMATION of the synovial membrane (or *synovitis*) may be produced by *local* or by *constitutional* causes. The former are, blows, strains, mechanical injuries, and especially penetrating wounds. The latter are, exposure to cold, and the rheumatic, gouty, syphilitic, mercurial, and sometimes the gonorrhœal poisons. It very seldom attacks young children. The joint most frequently affected is the knee.

Symptoms.—In the most acute form, the symptoms are severe aching pain in the joint, aggravated by the slightest motion; great

* Hamilton's Practical Treatise on Fractures and Dislocations, published at Philadelphia by Blanchard and Lea, 1860, is a good book on the subject.

and there is a great fulness at
frout part of the thigh. In th
above and between the olecranor
shoulder there is a general fulne

Prognosis.—This disease is r
joint solely, and more particula
(especially a penetrating wound
and arises from constitutional dis
will be proportionate to the sever
rapidity and sharpness of the pu
show great peril.

Morbid Anatomy.—In slight

cerates. In other severe, but more protracted cases, the membrane becomes thickened, pulpy, and highly vascular; granulations form on its surface and project like fringes into the cavity of the joint, and at the same time the cartilage ulcerates.

Treatment.—In all cases arising from injury, the joint, or rather the whole limb, should be confined by a splint, so as to keep it perfectly motionless. This is indispensable; for the joint cannot be kept motionless without it. The best splint is very thick leather or pasteboard, which admits of being easily adapted to the surface of the joint when softened in warm water; but, during the acute stage, a long wooden splint, properly padded, should be arranged so that it may be fastened to the limb at some distance above and below, and so that it may not touch the joint itself. If the knee is the part affected, it should not be allowed to become bent on the thigh, or if it is already bent, it should be brought as nearly straight as possible. The other measures are leeches in abundance *to* the joint, or cupping *near* it; ice, evaporating lotions, or warm poppy fomentations, according to the patient's choice; a good dose of calomel, followed by saline purgatives, till the motions are no longer dark and offensive: the treatment should be commenced by thorough purgation: then opiates at night to relieve pain. A warm poultice of camomile flowers, boiled till they are quite soft, or bran poultice, sprinkled with laudanum; or cotton wool covered with oiled silk, will generally be found more soothing than cold applications. Blisters are inapplicable till the acute stage is subsiding. A Salter's swing (see Index), is a very valuable adjunct in treating acute inflammation of the knee and ankle joints, and gives much ease to the patient.

When the disease is manifestly connected with rheumatism—when it is attended with red sediment in the urine and acid perspirations, and affects several joints, and extends to the synovial sheaths of tendons, after due purgation, as described above, colchicum should be administered every six hours (F. 69, &c.); if this fails, iodide of potassium (F. 95), with F. 72 at bed-time; when the fever subsides, guaiacum may be given.

When there is a tendency to gout, and the patient complains of grinding, excruciating pain, as if the joint were torn asunder, the colchicum is also the main remedy. In syphilitic cases (which will be known by the patient's general history, by his wan, peculiar appearance, and most likely by the existence of papular or other eruptions, vide p. 209), mercurial fumigation may be tried when the acute symptoms have subsided; but if it has, or if the constitution is broken down, recourse may be had to the iodide of potassium in doses of gr. iii. ter die, with a small dose of colchicum and opium at night; and sarsaparilla or cod-liver oil should be given in abundance. F. 82, 83. In all these cases warm baths, in which a quantity of carbonate of soda or potass has been dissolved, will probably be of service.

II. CHRONIC INFLAMMATION of the synovial membrane is characterised by *swelling* of the joint, of the same nature that attends the

and fluctuation. This constitutes p
Sir B. Brodie, as *pulpy degeneration*
thickening from deposit of unhealthy
to ulceration of the cartilage and d
these cases have their origin in necr
forming the joint close to the artic
synovial membrane and setting up d

The *causes* are the same as those
be a sequel.

Treatment.—The indications are,
order; secondly, to reduce inflammat
sorption of the effusion and thicke
proper uses.

In the first place, therefore, if the
depends on gout, it must be treated
especially the decoction of aloes and
habit is rheumatic, colchicum, or the
F. 56, 57, must be resorted to; and
lowing syphilis or gonorrhœa, warm-b
and carefully-regulated diet will
Chap. VI., Sect. X.

Secondly, in cases arising from lo
activity about the inflammation (esp
at night), the part should be confined
and should be bathed with cold lotion
taken by leeches or cupping. Mild
tered, F. 63, &c.

The third indication is to be fulfill
with blisters; which are as serviceab
mental in the acute disease. They sh
be quickly healed up; and should not
superficial, as the knee. The strong

useful applications for the convalescent stage of this and other chronic diseases of joints. It is applied thus: the surface of the joint, having first been washed with camphorated spirit, should be covered with the ointment thickly spread on lint; next, adhesive plaster should be evenly applied in strips, so as to form a complete casing for the joint; and lastly, a bandage. When the knee is bandaged in this way the adhesive straps should be arranged so as not to press too tightly on the patella. Supposing, *after inflammation has subsided*, the joint is left stiff,—the knee, for example, in a half-bent state—a process of very gradual extension may be set about by means of splints with a screw attached; but the greatest care must be taken not to light up a fresh inflammation.

III. Abscess in Joints.—If after acute or chronic inflammation, a joint becomes very much distended, and somewhat œdematous, and there is constant pain unmitigated by remedies, with rigors, a quick pulse, and considerable constitutional excitement, suppuration of the synovial membrane may be fairly suspected. The first thing to be done under these circumstances is to make a puncture with a grooved needle, and examine the fluid that exudes. If it is serum, two or three more punctures may be made, and an exhausted cupping-glass be applied over them; and by these means the part may be very safely and expeditiously relieved of a considerable quantity of fluid. If it is pus, a free opening should be made, so that the matter may run out easily; the joint should be placed on a splint in the most easy and convenient posture: the general health should be amended by tonics, alteratives, and proper diet; and then, in favourable cases, a cure will be effected by *anchylosis*. But if the suppuration and constitutional disturbance increase, the limb must be amputated, or the joint excised. In the elbow joint, excision should be always performed. In favourable cases the same operation may be practised in the shoulder, knee, and hip joints.

Purulent depôts in Joints.—It has been mentioned in several previous chapters, that a rapid effusion of puriform fluid into the joints and other parts is a frequent occurrence in puerperal fever, erysipelas, and other cases in which the blood is contaminated by a morbid poison. The part becomes red and painful, and very soon afterwards is found to be filled with pus. The only local treatment consists of a free incision in a depending position, and a splint with a bandage to prevent accumulation of matter.—See *Pyæmia*.

IV. Chronic Rheumatic Arthritis (*Nodosity of the Joints*) is a disease characterised by peculiar alterations of all the tissues of one or more joints. Joint *cavities* are enlarged and made hollower. The *heads of bones* are irregularly enlarged, and flattened; with overhanging mushroom-like borders, and often a great variety of projections and pedunculated exostoses around. The *cartilage*, as we learn from Mr. William Adams, seems to take the first step in the morbid process, becoming greatly hypertrophied, and afterwards ossifying. Yet wherever it is exposed to friction, the covering of cartilage is generally worn

bed at night. It is not usually aggr
surfaces against each other. The joi
limited, and often attended with an a
The muscles around it become waste
When the hip is the part affected, t
acute angle with the hip; the step is
the limb on the pelvis, as in going up

In the shoulder joint, which is frequ
glenoid cavity has been found

There can be no doubt that these appearances have been occasionally mistaken for the results of injury—such as rupture of the biceps, or unreduced dislocation.

This disease may invade almost any joint, but especially the hip, the shoulder, the joints of the hand, and especially that between the thumb and carpus, and those of the spine.†

The causes are obscure, but are referred to the rheumatic or gouty diathesis, or both. Young women may be attacked at puberty, or middle-aged women at the cessation of the menses, or persons much exposed to cold and wet; but it is the aged who are the peculiar victims of this disease. Any blow or bruise is liable to act as an exciting cause. See *Dislocations of the Shoulder and Fractures of the Hip.*

The *treatment*, not very successful at the best, consists in the use of warm aperients, antacids, and medicines reputed to possess anti-rheumatic virtues, such as the warm purgatives and tonics under F. 37, 38, 55, 56, 72, 73, and 7; in fact, rhubarb, beaume de vie, guaiacum, ammonia, sulphur and bark, with generous diet, opiate embrocations, flannel bandages, and warm *douches*, especially of the Bath waters. The chloride of arsenic has been recommended. Vapour or Turkish baths may be tried.

V. LOOSE CARTILAGES commence as little pendulous growths upon the synovial membrane, which become accidentally detached. They occur most frequently in the knee.

Symptoms.—They can be felt when they present themselves at the surface of the joint; and when they get between the ends of the bones, which they are very apt to do during exercise, they cause sudden excruciating pain and faintness, followed by inflammation.

Treatment.—If possible, the loose body should be fixed by bandages, so as to prevent it from getting between the bones, otherwise it must be removed by subcutaneous incision, a plan which seems to have been

* This cut shows the head of a femur, the preceding one the corresponding acetabulum affected with chronic rheumatic arthritis; from specimens belonging to E. Canton, Esq.

† R. W. Smith, on Fractures, &c. near Joints; B. Bell, on Diseases of the Bones, 1828; Edwin Canton, Surgical and Pathological Observations, 1855; W. Adams, on Enlargement of Articular Extremities of Bones in Chronic Rheumatic Arthritis, Pathological Trans. vol. iii.; R. W. Smith, on Chronic Rheumatic Arthritis of the Shoulder, Dublin Quarterly, Feb. 1853.

subacute rheumatism.

II. RELAXATION.—If any joint ha
cially if its innervation be impaired, it
relaxed and elongated, so as even to pe
to which they are attached. Thus, in
which followed an attack of hemipleg
capsular ligament of the hip were so el
of the femur to slip out of the acetal
ensue from

relaxation occurring to weakly children may be cured by good diet, tonics, and friction.

SECTION III.—THE CARTILAGE.

I. THE DISEASES of articular cartilage have been particularly studied by Professor Redfern of Aberdeen, who has shown that any disturbance whatever of their nutrition by injury or disease, produces one and the same change in their structure; viz., that the cartilage cells enlarge, become crowded with corpuscles by excessive proliferation, and lose their cell-wall; so that the contained corpuscles are either mingled with the intercellular tissue, or else are discharged on the surface of the cartilage, if near it. Meanwhile the intercellular or hyaline substance may soften into pus, or may become fibrous.*

II. THE REPARATION of cartilage after injury or disease is effected by the conversion of the softened intercellular substance into white fibrous tissue, and of the nuclei that have escaped from the cells into yellow fibres, which together form a cicatrix.

III. ULCERATION of cartilage consists in the progressive disintegration of the softened hyaline substance, and in the bursting of the cells and discharge of their contents. The pathological importance of this morbid process has been very much diminished by the discovery that it may exist to a considerable extent, even in the knee-joints of persons accustomed to bear heavy burdens, without any symptoms whatever. The cartilage may also, whilst preserving its healthy structure, wear away gradually in old men and animals, till it leaves the bone quite bare; the latter becoming dense, smooth, and polished,† yet with no symptoms except a slight grating. Ulceration of cartilage may occur as the result of any severe disease of the synovial membrane or of the bone. But it appears that it may exist by itself, without any disease of the other joint textures, and without any symptoms. It seems, therefore, that whatever grave importance may be attached to this process belongs really to the disease of bone, or of synovial membrane which accompanies it.

SECTION IV.—SCROFULOUS DISEASE OF JOINTS, WHITE SWELLING, AND ARTICULAR CARIES.

I. IN THE ADULT.—In persons of unsound constitution, any neglected injury or inflammation of any one of the joint structures is liable to lead to total and irreparable disorganization of the joint; including complete ulceration or destruction of the cartilage, caries of the

* P. Redfern, M.D., on Anormal Nutrition in Articular Cartilage, Edinburgh, 1850; and on the Healing of Wounds in Articular Cartilage, Edinburgh Monthly Journ. Med. Sciences, Sept. 1851. One starting-point of the "cellular pathology."

† This change is said to occur in the astragali of old draught horses, without occasioning any inconvenience to the animals. Richet, Brit. and For. Med. Rev., Jan. 1846. Mr. Quekett, quoted in Canton, op. cit. See also William Adams, op. cit.

bones, conversion of that part of the synovial membrane which lines the ligaments into a yellow gelatinous substance; softening and ulceration of the ligaments; and conversion of all the tissues around the joint into a gelatinous substance, riddled with abscesses, in which all natural distinction of structure is lost.

This condition may be produced in the scrofulous adult by an insidious idiopathic disease, which was formerly called *chronic ulceration of cartilage*.

Symptoms.—For the first few weeks (or perhaps months) of this disease the patient complains only of slight occasional rheumatic pains, perhaps flying about and affecting several joints, but at length settling decidedly in one. After a time, the pain increases in severity, especially at night, and it is generally referred to one small spot, deep in the joint, and is compared by the patient to the gnawing of an animal. Moreover, it is usually accompanied by an aching of some other part of the limb: thus, when the hip or elbow is affected, there is an aching of the knee or wrist; but it is important to notice that both the pain in the affected joint and the sympathetic remote pain are always aggravated by motion of the joint, and by pressure of the articular surfaces against each other. As the disease proceeds, the suffering becomes most excruciating, and is attended with painful spasms and starting of the limb during sleep; so that the patient's rest is broken, his spirits exhausted, and his appetite and general health rapidly impaired. At first the pain is unaccompanied with any swelling; in fact, this symptom never appears in less than four or five weeks, and often not for as many months, and when it does appear it is slight; and as it depends on an infiltration of the tissues *around* the joint, and not on effusion *into* it, the shape of the joint is not so much altered at first, but soon becomes more rounded, pulpy, and equally soft at all points, till it finally assumes the appearance of a globular enlargement which contrasts very strongly with the wasted condition of the limb above and below. The tissues are then brawny and exsanguine, giving a white appearance to the joint, marbled by blue veins upon the surface.

Terminations.—In fortunate cases, that are subjected to judicious

treatment at an early stage, the disease may be arrested, and the patient recover with a stiff or anchylosed joint; but in unfavourable cases, the

* Sketch of diseased knee, from a patient of Dr. Paul's, at Camberwell House Asylum. The tibia and fibula dislocated backwards.

cartilage is entirely destroyed; the bone can be heard to grate on the least motion; suppuration occurs into the joint, and numerous tortuous abscesses form around it; the surrounding soft parts are disorganized; the ligaments are destroyed, so that the flexor muscles, which have long kept the joint immoveably bent, at last dislocate it: if the knee is affected, for instance, the head of the tibia is drawn backwards into the ham, as in the foregoing sketch; and at last the patient, unless relieved, dies exhausted.

II. In Children, and in some adults, the disease may begin very insidiously; with slight lameness or *weakness*, as it is called, of the limb, and wasting of the muscles, and very little pain except after exercise. Then succeeds a swelling of the joint, and of all the textures round it; with increased wasting of the limb, and flexion and distortion of the joint. This may be followed by abscess.

Pathology.—The most essential circumstance to be regarded in this disease is the constitution. Whether in adults or in children, this is sure to be of a debilitated scrofulous sort. Regarding the local changes, they may commence in the synovial membrane; 2, in the cartilage; 3, in the bone; 4, in the parts around.

1. Acute or chronic synovitis, especially if the result of injury, in a person of bad constitution, will very frequently cause destruction of the cartilage, and caries of the bone, suppuration in the joint, and the other train of symptoms just described. This case will be known by the swelling from effusion into the joint in the early stage.

2. Whether ulceration of the cartilage alone, without morbid change in the bone or synovial membrane, is capable of giving rise, as is commonly supposed, to the disease just described above, must, after Dr. Redfern's researches, be considered doubtful. It is more than probable that some morbid state of the bone, or of the synovial membrane, or of both, accompanies it from the first.

3. In the case of scrofulous children, it seems pretty certain that the disease commences with caries of the cancellous texture of the articular extremity of the bone. The affected bone is found to be soft, red, and easily crushed; its cancelli are filled with a reddish granulation, sometimes with inspissated pus, or "tubercle." Owing to the softened state of the bone, the cartilage peels off from it readily. When peeled off, its under surface is probably

* This cut exhibits caries of the astragalus, with incipient separation of the cartilage. From the King's College Museum. The next shows a state approaching to *spina ventosa*.

formerly called *spina ventosa*; the
becomes greatly enlarged by superfi
into a mere shell by caries in its int

The *prognosis*, in the first stage, th
may be favourable; but after swelli
patient will be fortunate in recoverin
puration, he will, if an adult, be alı
excision.

4. In some instances, as the antho
be disorganized through the presence
puration into the *areolar tissue* con
no particular observation, except tha
opened early.*

Treatment.—If there be much pai
measure is *perfect rest;* which must
(if one of the lower joints of the le
those of the arm), confining the joint
tight) or splint of gutta percha, or
water, accurately moulded to the pa
The use of splints is two-fold. First,
to insure rest. But we do not inten
scrofulous disease of knee, or hip, or
at rest during the whole course of the
the convalescent stage the patient m
joint bandaged, and the leg supported
to get fresh air and exercise; provid
sioned. 2. Occasional *leechings* may
the pain is severe. But loss of bloo
dental fits of inflammation. 3. *Count*
caustic issue, or the actual cautery, i
repute formerly than it is now; the c
able are the very painful joint ulce

whole joint, is also of great value as a stimulating counter-irritant of much power. If the knee is affected, a small caustic issue may be established on each side of the head of the tibia, and may be kept open by an occasional touch with caustic potass or sulphate of copper. The actual cautery is exceedingly efficacious as a counter-irritant, and the patient may be rendered unconscious of it by chloroform.* Sir B. Brodie has shown that issues, when long established, sometimes irritate the constitution, bringing on a return of the pain which they relieved at first, and which will again depart if they are healed up. It is a practical rule, therefore, to give them up for a time, before condemning a joint to excision. For children, if counter-irritation is deemed necessary, blisters answer very well. 4. The ointment of Scott, applied as described in a preceding page, will often be found a useful auxiliary to time and quietude. 5. *Mercury*, given so as gently to affect the system, was believed by Sir B. Brodie to be of great benefit in the case of adults.† 6. In other cases, the treatment must be that which we have prescribed for scrofula: cod-liver oil; iodide of iron or of potassium; sarsaparilla; nutritious food; and sea-air, so soon as the patient is able to go out. Pain must be allayed by hemlock or opium. 7. There can be no doubt that recovery is often prevented by the presence of pus, and of the débris of bone and cartilage in the cavity of the joint. When suppuration, therefore, has taken place, it seems rational not to let the matter burrow and establish sinuses, and disorganize the surrounding textures, but to adopt Mr. Gay's plan, and freely lay open the joint by longitudinal incisions, or else introduce Chassaignac's drainage tubes. Thus, an exit being provided for discharge, the parts will be relieved of one obstacle to recovery. Besides, weak injections of iodine, dilute nitric and phosphoric acid, and other applications, may be made to the diseased surfaces, and carious or necrosed portions of bones be removed. 8. If all other measures prove unavailing, and the health is sinking, the diseased articular surfaces should, if possible, be cut out; otherwise, the limb should be amputated.

* Refer to the Index.

† Lectures, Med. Gaz. vol. xxxvii.

leg. Moreover, in almost every c
surgeon is on his guard to prevent it,
position, in which it will remain till
paralyzed, and the flexors shortened
traction of these muscles aids in diso
one bone from another, as is constantl
hip. There are three varieties of anc
1. *The spurious* or *false* anchylosis

tion. 1st. There is the category of

fitted to a splint with a hinge in it, may also be used for the purpose of gradually straightening out the joint.

2ndly. A more active set of proceedings consists in dividing, by subcutaneous section, the tendons of any muscles, or any fascia, or even any muscular fibres, whose rigidity is an obstacle (see *Tenotomy*). Immediately after this operation, pressure should be applied to prevent bleeding, and the wound should be allowed to heal. Then a fresh attempt may be made under chloroform; and if it can be done without too great violence, the joint may be forcibly extended so as to tear through bands of fibrous tissue in or around the joint. At the same time any degree of subluxation or displacement may be rectified. After the operation the limb must be put in an easy posture on a splint, and the case be treated like a recent sprain, till inflammation has subsided; then gentle passive motion will probably entirely restore the use of the limb after some weeks of treatment.*

When the knee-joint is concerned, the hamstring muscles, and portions of fascia, may probably require division. If the elbow, the aponeurotic offshoot of the biceps. The knee may be straightened by pressure; the elbow likewise by main force. The pectoralis major, latissimus dorsi, teres major and minor were divided by Dieffenbach to effect reduction of an old dislocation of the shoulder; and the pectineus and sartorius by an American surgeon in a case of contracted hip.

3rdly. If the anchylosis is bony and extensive, there is no resource except to saw through the bone, or cut out a wedge-shaped portion, and then employ sufficient motion to establish a false joint. This operation was successfully performed by Dr. Rhea Barton, of Philadelphia, on the hip in 1827, and on the knee in 1838. It was also successfully performed by Dr. Gibson, of Philadelphia, in a case of complete anchylosis of the knee, with not a vestige of ligament, cartilage, or synovial membrane remaining. Having laid bare the front of the joint by a V incision above the patella, he sawed out a wedge-shaped portion of the bone, and gently bent the rest so as not to endanger the popliteal vessels.† But of course this is so serious an operation, that it must not be undertaken without balancing the advantages with the risks of it. Moreover, before having recourse to it, the surgeon should try fairly whether the joint can be bent by main force; for it need scarcely be said that the rupture of any amount of fibrous tissue, or fracture of bony tissue without wound of skin, is a very much safer proceeding than the making a deep wound involving the bone.

* See paper by Mr. Brodhurst on Forcible Extension and Rupture of uniting medium of partially anchylosed surfaces. Med. Chir. Trans., vol. xl.

† Vide American Journ. Med. Sc., July, 1842, and a case by Dr. Buck, Ranking's Abstract, vol. iii. For further information, consult Fergusson, op. cit.

foot and dragging of the leg, and la
becomes very excruciating in the ca
in those of scrofulous caries it is co
forms it is felt chiefly in the knee;
pain in the knee may be the only sy
may even be some swelling there.
the surgeon presses on the hip-joint,
iliacus, or behind the great trochante
the acetabulum by a sharp tap on t
will be felt in the hip, and the p
aggravated.

After these symptoms have gone
the nates become flattened, its lower
limb weaker; and it is noticed that t
be, longer than the sound one, a length
in some slight degree on effusion in
protrusion of the trochanter; but m
the patient's habit of standing with
the sound limb, and of lowering the
stretching out the diseased leg to s
instead of being lengthened, the limb i
in the adjoining cut (Fig. 1), which
a patient of Mr. Partridge's, in the
apparent shortening is caused by con
vaginæ femoris, psoas, and iliacus, an
throw the limb into an easy posture;
is not to be seen in all cases.

But if the disease proceed, there c
caused either by absorption or by car
by the destruction of the acetabulum
cation of the bone upwards by the

or outwards, as in fracture of the neck of the femur: this is accidental. This organic shortening is usually attended with an increase of the pain, and of the starting of the limb during sleep, and is in most cases (but not all) soon followed by abscess, which may burst on the nates,

Fig. 1.

Fig. 2.

above or below the glutens maximus, or the groin, between the psoas and pectineus, on the inner side of the vessels, or may burrow between the muscles of the thigh; or the acetabulum may be perforated, so that matter passes into the pelvis and bursts into the rectum. From this suppuration stage it is exceedingly rare for an adult to recover, although, in the case of children, the prognosis is not unfavourable, if the strength is pretty good, and the lungs free from disease; and the patient may be so fortunate as to recover with an anchylosed hip. The

duration of the disease may vary from two or three months to several years.

Diagnosis.—From *psoas abscess* it may be distinguished by the absence of pain in the back, and of tenderness on pressure in the iliac and lumbar regions. Psoas abscess also points on the outside of the femoral vessels below Poupart's ligament. From *chronic rheumatic arthritis*, by the history of the case, the age of the patient, the irregular hardness caused by ossified growths around the joints, the absence of audible crepitation, and by the pain caused by pressing the articular surfaces against each other; which is not a character of the chronic rheumatic affection. Yet it must be remembered that this latter disease may lead to abscess if the patient meets with injury. The great pain caused by pressing the femur against the acetabulum will distinguish this disease from *sciatica*.

Treatment.—This must of course be the same in principle as the treatment of other diseased joints. If the patient comes under treatment in the earliest stage, the limb should be maintained at *perfect rest in the straight posture*, by means of a straight splint reaching from

the axilla to the foot, or by sandbags. If distortion has already commenced, a bandage of leather or pasteboard should be applied; and the patient should not be permitted to lie constantly on the sound side, else the distortion of the spine and the chance of dislocation will be enhanced. Cupping or leeching, if there is considerable pain and tender-

* Sketch of the patient from whom Mr. H. Smith removed the head of the thigh bone. It illustrates the extraordinary attitudes which patients are liable to acquire. The dotted lines show the course of Mr. Smith's incisions.

ness, with strength sufficient, will be of great service in the early stages, and a grain of grey powder with henbane may be given nightly. F. 63, 64. But the principal dependence is to be placed on cod-liver oil and tonics, and on counter-irritation by means of a succession of small blisters around the hip, or at the anterior edge of the tensor vaginæ femoris, or by a seton in the groin. When abscess forms, it should be opened subcutaneously, or by drainage tube, so as not to let the air enter the cavity as the pus escape.

The *position* of the patient in bed is a point of considerable importance, since if left to himself he is apt to acquire the most distorted and ungainly attitude. "The following contrivance," says Mr. Coulson, "will be found very useful;—a double-inclined plane should be formed by joining two portions of wood together in such a manner that when the child's hams are made to correspond with the angle of junction, his legs and feet should extend down one plane, and there be confined to the foot-boards by rollers, whilst his thighs and buttocks extend down the other. The foot-boards will also have the beneficial effect of removing the weight of the bed-clothes from the feet. Opposite the anus a small opening should be made to admit the passage of the fæces. The whole trunk of the child should lie quite horizontally on the bed."

The *prone position* is recommended by Coulson in the latter stages, as it avoids pressure on diseased and ulcerated hips; it allows dressings to be readily applied, and counteracts the patient's habit of lying with the diseased limb drawn up across its fellow. A couch is constructed with an angle, corresponding to the bend of the hips; it has one part horizontal on which the abdomen and chest repose, while the pelvis and legs hang down an inclined plane.

In cases in which a carious head of the femur keeps up constant irritation and discharge, with no chance of benefit from ordinary local or constitutional remedies, whilst the acetabulum and bones of the pelvis, as well as the lungs, kidneys, and other viscera are so free from active disease as to give a fair chance of recovery, *excision of the head of the femur* may be proposed.

This operation was first performed by Mr. Anthony White in 1821, with perfect success, although Sir E. Home and the medical officers of St. George's Hospital gave it as their opinion that it would be useless, impracticable, and fatal. It was revived by Professor Fergusson in 1845, and has since that time been performed not only by that gentleman, but by Mr. Simon, Mr. H. Smith, Mr. French, Mr. Haynes Walton, Mr. Cattou of Lynn, Mr. Morris of Spalding, Mr. Jones of Jersey, Professor Buchanan of Glasgow, and Mr. T. Holmes, and with such an amount of success that it may now fairly rank amongst the established operations of surgery; and it is a strong argument in its favour that the acetabulum, although originally involved in the disease, yet frequently sets up a process of repair, and becomes filled with fibrous membrane, as soon as it is relieved by dislocation from the presence of the carious head of the thigh-bone. It is not a difficult proceeding. An incision five or six inches in length is made over the diseased and displaced bone;

another at right angles across the trochanter; the soft tissues are cleared away from the bone (they consist of little more than skin and cellular tissue, for the thick muscles which cover the part in health are long since wasted), the saw is applied below the trochanter, and the

head of the bone with that process removed. The adjoining cut shows the portion of bone removed by Mr. H. Smith. Any necrosed or carious portion of the acetabulum should be got away if possible. After the operation the limb must be brought into the straight position, and be kept at rest by means of a long splint, and the case be treated on general principles. If everything goes on well, the patient will recover a useful limb with a considerable degree of motion at the hip, and can walk comfortably with a high-heeled shoe.*

SECTION VII.—NEURALGIA OF JOINTS.

The characters of neuralgic pain, as distinguished from that which accompanies organic disease, have been described under the head of Hysterial Neuralgia (see p. 11); but we introduce this short section in order to remind the young surgeon of the possibility of mistaking hysterical pain for ulceration of a joint.

SECTION VIII.—WOUNDS OF JOINTS.

Symptoms.—A wound may often, but not invariably, be known to have penetrated a joint, by the escape of synovia, in the form of small oily globules.

Treatment.—The object is to avert acute inflammation of the synovial membrane, which might prove fatal. If the knee be the part wounded, and there is comminuted fracture of bone or great loss of skin,

* Coulson, op. cit.; O'Beirne and Bellingham, on the use of Mercury in early stages, quoted in Ranking's Abstract, vol. x. p. 290; Fergusson's Surgery, 2nd edit. p. 469; Henry Smith, Essay in Lancet, 1848, vol. i. p. 361; Syme, Lancet, 1849, vol. i. p. 266 (*objects to the operation*); Cotton's case, Med. Gaz., 1847; case by Skey, Med. Gaz., Aug. 31, 1850; sequel to Fergusson's case by Smith, Med. Times, Dec. 4, 1852; T. Holmes, Lancet, Aug. 27, 1864.

excision may be requisite; if the popliteal artery is wounded, amputation. The wound should be carefully closed and covered with a piece of lint dipped in blood. The limb should be comfortably bandaged, and constitutional measures be adopted to avert or subdue inflammation. See Sect. I.

SECTION IX.—DISLOCATION OR LUXATION, GENERALLY.

Symptoms.—The characteristic symptoms of dislocation are two:—1. *Deformity*: there being an alteration in the form of the joint; an unnatural prominence at one part and a depression at another, together with lengthening or shortening of the limb. 2. Loss or deviation from the proper motions of the joint.

Causes.—Dislocation may be caused by external violence, or by muscular action. And the circumstances that enable muscular action to produce it are,—a peculiar position (as when the jaw is very much depressed); paralysis of an antagonist set of muscles; elongation of ligaments; or fracture or ulceration of some process of bone. Thus, ulceration of the acetabulum permits the head of the femur to be dislocated upwards, and fracture of the coronoid process permits the ulna to be dislocated backwards.

Morbid Anatomy.—Dislocation is almost of necessity attended with some rupture of ligaments, which, however, readily unite and heal. If the dislocation be left unreduced, the lymph thrown out around the head of the bone in its new situation becomes converted into new ligaments, and into a new socket, which is lined with a smooth ivory substance, and not with cartilage; and a very useful degree of motion is often acquired. Meanwhile the old socket gradually becomes filled up.

Diagnosis.—Dislocation may be distinguished from fracture, 1. By the *absence of crepitus*. For although a slight *crackling* is often perceptible, owing to an effusion of serum into the cellular tissue, it can hardly be mistaken for the *grating* of fracture. 2. By the circumstance that the surgeon can move a fractured bone more freely than is natural, and a dislocated one less so. 3. By *measurement* of the bone supposed to be broken, which, if broken, will be most probably shortened. 4. If a fractured bone be drawn into its proper shape, the distortion will return so soon as the extension is discontinued; if a dislocated bone be drawn into its proper place, it will usually remain there.

Treatment.—The reduction of dislocations is to be effected by getting the head of the displaced bone into such a position that the muscles may draw it into its socket. Sometimes this may be done by *manœuvring*, as in certain ways of reducing dislocated shoulders and hips, that will be presently described; sometimes main force must be used; the socket being fixed on one side, and the bone pulled on the other till the resistance of the muscles is overcome. The extension should be made in such a position as to relax as many of the opposing

muscles as possible, and should be aided by gentle rotation and such other movements as may help to dislodge the dislocated part. After reduction, leeches, fomentations, and purging must be used, if required, to prevent inflammation, and the joint should be kept at rest till any laceration of its ligaments may have healed, otherwise the dislocation may be perpetually recurring.

Dislocations should always be reduced as quickly as possible, before the patient has recovered from the shock of the injury, and before the muscles have had time to contract and fix the bone in its new situation. The patient should be put under the influence of chloroform, in order to prevent involuntary resistance of the muscles; a much safer thing than the bleeding, the half-grain doses of tartar-emetic, and the hot bath that were formerly prescribed.

COMPOUND DISLOCATION is a dangerous accident, because of the actual synovial inflammation, rapid ulceration of cartilage, and violent constitutional disturbance, with which it is liable to be followed. The necessity of excision or amputation will depend on precisely the same contingencies as in compound fracture:—old age; bad constitution; shattering of the bone; extensive bruising or laceration of the integuments, so that the wound cannot be closed; laceration of large blood-vessels, which will often require amputation or excision: as a rule excision is to be preferred to amputation in these cases. If the limb is to be saved, the dislocation must be reduced; if the end of the bone protrude through the skin, and render reduction difficult, it must be sawn off, or the aperture must be slightly dilated; the wound must then be closed, and covered with a piece of lint dipped in blood; and the case be treated as a wounded joint.

DISLOCATION AND FRACTURE.—Supposing the femur or humerus to be dislocated and fractured also, Sir A. Cooper directs the fractured part to be first well secured in splints and bandages, and then the dislocation to be reduced without delay. Because if the dislocation is not attended to till after the fracture has united, the difficulty of reducing it will be very much increased through the lapse of time; and, perhaps, the bone may be broken again during the forcible extension that will be necessary.

CONGENITAL DISLOCATION is the result of original want of development, or of intra-uterine disease, and is mostly incurable.

SECTION X.—PARTICULAR DISLOCATIONS.

I. DISLOCATION OF THE JAW may be caused by a blow on the chin, when the mouth is wide open, or by spasm of the external pterygoid muscles, by which the articular condyles are drawn over the transverse root of the zygomatic process.

Symptoms.—The mouth fixedly open, the patient unable to shut it; speech and deglutition almost impossible; saliva dribbling away; the chin protruding forwards; and the condyle felt to project unnaturally under the zygomatic process, whilst the finger sinks into the parotid

space. If one side only is dislocated, the chin will be turned towards the opposite.

Treatment.—The surgeon should first fix the head carefully against a wall, or high chair; next, wrap a napkin round his thumbs, and place them at the roots of the coronoid process behind the molar teeth; then he should press them downwards and backwards, elevating the chin at the same time with his fingers. Or he may place the handle of a fork on the last molar teeth, and depress them with it, using the upper teeth as a fulcrum. Or a piece of cork may be put between the molar teeth in order to act as a fulcrum, whilst the chin is elevated. After reduction, the chin must be confined for a week or two by a *four-tailed bandage.*

II. DISLOCATIONS OF THE CLAVICLE.—The *sternal extremity* of this bone may be dislocated *forwards* by blows on the shoulder. It can readily be felt on the anterior surface of the sternum. It may also be displaced upwards upon the end of the sternum. The *treatment* is in all respects the same as for fractured clavicle, with the addition of pressure by the thumb on the displaced end of the bone. Dislocation of this end of the bone *backwards* has been caused by curvature of the spine. In one case it produced so much pressure on the œsophagus as to threaten starvation, and was in consequence extirpated by Mr. Davie of Bungay. There are also a few cases on record of dislocation of this end of the clavicle backwards by violence. Pain and difficulty of breathing are the consequences; the reduction and subsequent treatment the same as for the dislocation forwards.*

‡

The *outer extremity* of the clavicle may be dislocated *upwards* on the acromion. The shoulder is sunken and flattened, and on tracing the spine of the scapula, the end of the clavicle can be felt upon the acromion. The outer extremity of the clavicle has also been known to be dislocated *under* the acromion by a kick from a horse on the shoulder.† The treatment is the same as for fractures of the clavicle or acromion. (See p. 262.)

* Vide a case by M. Pelletux in the Revue Médicale, Aug. 1834, p. 151, and another by Mr. Brown, of Callington, Med. Gaz., Aug. 1, 1845.

† Forbes's Rev., vol. vi.

‡ Dislocation of the shoulder downwards.

III. DISLOCATION OF THE SHOULDER-JOINT may occur in three principal directions. The head of the humerus may be thrown downwards, forwards, or backwards; besides which, it may be partially dislocated forwards and upwards.

1. In the dislocation *downwards or into the axilla*, which is the most common, the head of the bone slips between the subscapularis muscle and the long head of the triceps, and rests upon the outer or axillary border of the scapula, pressing upon the axillary plexus of nerves, between the subscapularis muscles and the ribs.

Symptoms.—The arm is lengthened; a hollow may be felt under the acromion, where the head of the bone ought to be; the shoulder seems flattened; the elbow sticks out from the side, and cannot be made to touch the ribs; and the head of the bone can be felt in the axilla, if the limb be raised; although such an attempt causes great pain and numbness.

Diagnosis. — There are three fractures liable to be mistaken for this dislocation, viz., fracture of the *acromion*; of the *neck of the scapula*; and of the *neck of the humerus*. The first two may be known by the facility with which the form of the joint is restored by raising the limb, and by the crepitus felt on doing so. In fracture of the *cervix humeri*, the limb is *shortened*, instead of being lengthened as it is in dislocation, there is not so much vacuity under the acromion, and the rough angular end of the shaft may be felt in the axilla instead of the natural smooth head of the bone.

2. In the dislocation *forwards*, the head of the humerus is thrown on the inner side of the coracoid process, and may be felt under the clavicle.

Symptoms.—The arm is slightly shortened; the elbow projects backwards; the acromion seems pointed, especially behind, and the head of the bone cannot be felt under it.

3. In the dislocation *backwards*, the head of the bone may be felt on the dorsum scapulæ; and the elbow projects forwards. There is a fulness behind and a hollow under the acromion.

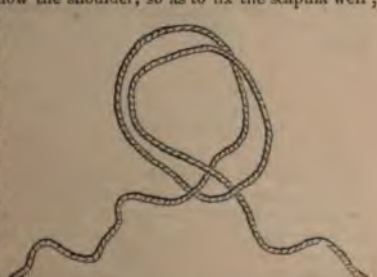
4. In the *partial dislocation forwards*, the head of the bone is

thrown partly off from the glenoid cavity against the coracoid process. The symptoms are, projection of the acromion and a hollow under it at

the back of the joint, whilst the head of the bone is prominent in front, and may be felt to move on rotating the elbow; cramps of the hand; and difficulty of raising the elbow, because the head of the bone strikes against the coracoid process.

Treatment.—There are five methods of reducing the first or downward form of dislocation.

1. *By simple extension.* A jack-towel is to be passed round the chest, both above and below the shoulder, so as to fix the scapula well; this should be held firmly. Another should be fastened round the arm, above the elbow, being tied in the knot called the *clove hitch*, represented in the annexed figure. Extension should then be made by the latter; the patient sitting on the floor, his elbow being bent, and the humerus being raised



* Partial dislocation unreduced. Head of humerus under coracoid process; the head of the bone and part of the glenoid cavity are worn away. St. Mary's Museum.

† Unreduced dislocation on the dorsum. A new socket formed. St. Mary's Museum.

the surgeon sits on the edge. He
into the axilla, to press the head
and at the same time pulls the limb
by means of a towel fastened round

4. By the *knee in the axilla*. Th
the surgeon places one of his knees i
chair. He then puts his hand on t
with the other depresses the elbow

5. According to the method inv
and revived by Malgaigne, the pati

behind him. The scapula is well fi
shoulder, or by passing a jack-towel
the opposite corner of the bed; the
and drawn straight up by the head,

by which the leverage afforded by the length of the limb is made available for tilting the head into its socket. For this purpose the elbow is straightened, and the limb raised and moved in a circular direction, so as to dislodge the head of the dislocated bone, and enable the muscles to draw it into its socket. Mr. Skey uses an iron knob, instead of the heel.

The extension used in reducing the dislocation *forwards* must be made in a direction downwards and backwards. For the dislocation backwards, extension should be made forwards.

After reduction a pad should be placed in the axilla, and the arm and shoulder be supported for some days with a figure-of-8 bandage, a few turns of which should confine the arm to the trunk. Warm fomentations—perhaps leeches—and subsequently frictions, will relieve the pain and swelling. The more weak and flabby the patient, or the oftener the dislocation has occurred, the longer will confinement be necessary, in order to allow of a complete consolidation of the ruptured ligament. In fact, when the dislocation has occurred more than twice, an apparatus consisting of a clavicle bandage, with a broad band round the head of the humerus, should be worn for some months, so as to restrain the motions of the joint.

It has been before directed that this and all other dislocations should be reduced as soon as possible after the injury. If the reduction has been delayed till the muscles have fixed the part, and the patient is robust, it may be necessary to bleed or administer tartar-emetic or chloroform, and to make a long, slow, and gentle, but unremitting extension by the pulleys. When the extension has been continued some time, the surgeon may gently rotate the limb by the fore-arm, or lift the head of the bone. If the dislocation has lasted some time, there will be still greater necessity for a tedious operation. Sir A. Cooper's opinion was, that a reduction ought not to be attempted after three months. But the criterion which Mr. B. Cooper proposed is a better one; and that is, the degree in which the arm has been exercised, and the amount of useful motion which it has acquired in its new situation; for, in proportion as the head of the bone has formed for itself a new socket, so most likely will the old socket have become unfit for its reception again. There are numerous instances on record, of the most disastrous and even fatal results that have ensued from attempts at reduction at a later period: the integuments and muscles have been lacerated; abscess has formed, and been followed by anchylosis of the joint; nay, even the whole side has been palsied from injury to the cervical vertebræ, and the axillary artery has been torn across.

Injuries of the shoulder-joint are liable to be followed by various obstinate and intractable affections, owing probably to the supervention of the state described at p. 294, as *chronic rheumatic arthritis*. The capsular tendons, and long head of the biceps waste away, and the articular surfaces are altered in shape, and partially displaced. Such cases were formerly described as *dislocation upwards, and rupture of the biceps*. Sometimes the deltoid muscle wastes away, owing, probably,

much behind; a hollow can be felt
the great sigmoid cavity; and the t
protuberance in front. The coron
humerus which naturally contains

2. In dislocation of *both bones ba*
process is thrown behind the extern
preceding symptoms, the head of th
the outer side of the joint.

3. The dislocation *backwards and*
jection of the outer condyle, in addi
variety.

4. In *dislocation backwards* of
much projected backwards, the elbow
and the forearm is much twisted and

The *treatment* of these four vari

5. The head of the *radius alone* may be *dislocated forwards;* being thrown against the external condyle. The elbow is slightly bent, and,

in bending it more, the head of the radius can be felt to strike against the front of the humerus.

Treatment.—Simple extension from the hand, the elbow being straight.

6. Dislocation of the *radius backwards* is very rare. The arm is bent, and the head of the bone can be felt behind the outer condyle. *Reduced* by simply bending and adducting the arm, which should be kept bent for three weeks.

Diagnosis.—These dislocations of the elbow may be distinguished from fractures of the lower extremity of the humerus—1, by the impaired mobility of the joint, and by the absence of crepitus; 2, by measuring the length of the humerus from its condyle to the shoulder; which, in dislocation, will be equal to that of the sound limb, but will be diminished in fracture of the lower extremity of the humerus. But when it is considered that these six dislocations may be combined with various fractures of the condyles of the humerus and of the bones of the forearm, it will be admitted that the injuries of the elbow present a sufficiently wide and complicated field of study.

V. DISLOCATIONS OF THE WRIST may readily be distinguished by the altered position of the hand, which is thrown either backwards or forwards if both bones be dislocated, or twisted if only one be displaced,—and by the alteration of the natural relative position of the styloid processes of the radius and ulna with the bones of the carpus. They are reduced by simple extension.*

VI. DISLOCATIONS OF THE HAND. — The *os magnum* and *os cuneiforme* are sometimes partially dislocated through relaxation of their ligaments, and form projections at the back of the hand, which must not be mistaken for ganglia. Mr. Fergusson has also known

* Dupuytren taught that these dislocations are extremely rare, or, in fact, almost impossible; and that fractures of the lower extremity of the radius are generally mistaken for them. But the experience of English surgeons shows that real dislocation, without any fracture, is not by any means uncommon. See a very carefully reported case in the Lond. Med. Gaz., June 17th, 1843.

and the small size of the part fi
firm hold may be obtained by
adhesive plaster where it is in c
knot called the *clove hitch*, rep
is a good plan to place a part o
located bone, so as to pull it st
sion should be made towards
muscles. But, "before the r
Liston, "it has been in some ca
of the ligaments; the external i
by introducing a narrow-bladed
skin at some distance, and dir
part."

In compound dislocation of t
metacarpal bone, the head of the
cannot be replaced and retained e
the second phalanx, it is better to
ject through the wound.

VII. DISLOCATION OF THE
torn from the extremity of the r
posterior extremity of the ribs
falls on the back: but these acci
in which the heads of the last tw
spine, in a boy of eleven, by a viol
and the case terminated fatally.*

the head of the bone is thrown on the dorsum ilii. 2ndly. The dislocation backwards on the sciatic notch; 3rdly, downwards, on the obturator externus muscle; and 4thly, forwards, on the os pubis. Besides which there are two or three others that are exceedingly rare.

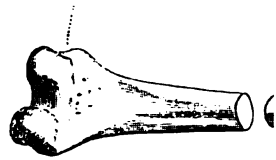
* Dislocation upwards of the Hip-Joint. From Sir A. Cooper.

† Dislocation backwards of the Hip-Joint. From Sir A Cooper.

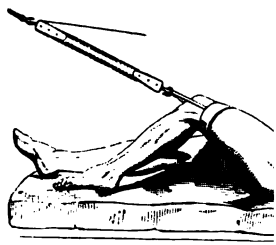
1. Dislocation *upwards on the dorsum ilii* is the most frequent.

Symptoms.—The limb is from an inch and a half to two inches and a half shorter than the other; the toe rests on the opposite instep; the knee is turned inwards, and is a little advanced upon the other; the limb can be slightly bent across the other, but cannot be bent outwards; the trochanter is less prominent than the other, and nearer the spine of the ilium; and if the patient is thin, and there is no swelling, the head of the bone can be felt in its new situation.

Diagnosis.—Fracture of the *cervix femoris* may be distinguished from this dislocation by the circumstance that the limb can be freely moved in any direction, although with some pain; that it is turned outwards instead of inwards; and that it can be drawn to its proper length by moderate extension, with some crepitus, but becomes shortened again as soon as the extension is discontinued: whereas in dislocation, it requires a forcible extension to restore the limb to its proper length



Treatment.—As we have said
be reduced by manœuvring or l
preferable plan if it can be adopte
The manœuvre by which a disl
called the *flexion method*) consist
as a lever and the trochanter as



surgeon then grasping the ankle with one hand, and the knee with the other, causes the thigh to perform a circular movement of abduction, finishing with a slight rotatory movement, when the bone will probably be replaced. Chloroform should be used, if there is any difficulty. See the diagram, p. 319.*

When the patient is old and of relaxed fibre, or of tender years, dislocations of the hip may be reduced by a method analogous to the *last in the axilla*. The surgeon sits and presses one foot against the perinæum, whilst extension and rotation are effected by his assistants.

But if main force must be resorted to, the patient must be thoroughly chloroformed, and placed on his back on a table; a leathern girth or strong towel should be passed round the upper part of the thigh, so as to bear firmly against the perinæum and crista ilii, as represented in the foregoing cut, which was sketched from nature by Mr. W. Bagg; and this should be attached to a ring or hook securely fastened into the wall or floor. A linen roller should next be applied to the lower part of the thigh, and over it the strap belonging to the pulleys; which last try to be fixed to the wall or some other firm object. Then extension is to be made in such a direction as to *draw the thigh across the opposite, a little above the knee*. After a little time, the surgeon should gently rotate the limb, so lift the upper part of it, and the head of the bone will probably return to the acetabulum. The patient should then be carefully moved to bed, with his thighs tied together. Mr. Skey advises extension to be made from the ankle, so as not to drag on the pelvis by the hamstring muscles. Another way is to lay the patient on the sound side and to

The foregoing diagram may explain the mechanism of reduction. The process is well summed up by a writer in Medical Times, 30th June, 1855:—"Lift up, bend out, roll in."—See case by Mr. Cock, ibid.

† Dislocation downwards. From Sir A. Cooper.

fix the apparatus with the extending or pulley side fixed higher than the counter-extending or body side.

2. The dislocation *backwards* (commonly called the dislocation *into the sciatic notch*) is a modification of the preceding, and is known by the following symptoms:—The limb is shortened from half an inch to an inch; the toes rest on the ball of the great toe of the other foot; the knee is advanced and turned inwards, but not so much as in the last case; the trochanter is rather behind its natural position, and not so prominent, and the head of the bone can scarcely be felt. This position of the head of the femur may be the result of ill-directed attempts to reduce a dislocation on the dorsum ilii.

Treatment.—Reduction by flexion if possible. If main force is used the patient should be placed on the sound side, and the limb be drawn across the middle of the opposite thigh. After a little while the upper part of the limb should be lifted by means of a napkin, so as to raise the head of the bone over the edge of the acetabulum, the thigh being at the same time rotated outwards.*

3. In the dislocation *downwards*, the head of the bone is thrown into the *thyroid foramen*, or on the *obturator externus*. The *symptoms* are as follow:—the limb is lengthened one or two inches; it is drawn away from the other; the toes point downwards and directly forwards; and the body is bent forwards, because the psoas muscle is on the stretch. In this, as in all other dislocations of the hip-joint, the ligamentum teres is torn across.

Treatment.—The object is to draw the head of the bone outwards, and rather upwards. There are two methods of effecting this. In the first place, the patient may be laid on his back on a bed, with one of the bedposts between his thighs, and close up to the perinæum. Then the foot may be carried inwards, across the median line; so that the bedpost, acting as a fulcrum, may throw the head of the femur outwards. But the foot must not be *raised*, otherwise the head of the femur may slip round under the acetabulum into the sciatic notch. (2.) Or the pelvis may be fixed sideways by a broad band, and the pulleys be applied to the upper part of the thigh, to draw it outwards at right angles to the body: whilst the knee is at the same time pulled downwards and inwards.

* The above account is condensed from Sir A. Cooper, op. cit. chap. 5. sect. iv. Mr. Richard Quain has published (Med. Chir. Trans. vol. xxxi.) an account of a careful dissection of a recent case of this injury, and of experiments made to determine the exact relation of the visible deformity to the true position of the head of the bone; and has concluded that, in the ordinary form of this dislocation, the head of the femur does not reach the sciatic notch, but is lodged immediately behind the acetabulum, over the base of the ischiatic spine, and opposite to a small part of each of the two sacro-sciatic foramina; that the advanced position of the displaced limb at the knee, and the situation of the foot with "the toe resting against the great toe of the other foot" are not necessarily present; that during the extension the thigh should be at a right angle with the abdomen, and in a state of abduction; that the extending force should be applied above the knee; and that this joint should be bent in order to relax the sciatic nerve, which runs either immediately before or behind the displaced head of the bone.

the dislocation *upwards and forwards* (on the pubes), the limb
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ment.—Flexion may
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little time, the head
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edge of the acetabulum by means of a napkin.

stley Cooper decided that eight weeks is the latest period after
t is justifiable to attempt the reduction of a dislocated hip,
n persons of extremely relaxed fibre or of advanced age; and
ne instances are on record of death from abscesses or phlebitis,
ed by violent extension at a later period.

respect to the relative frequency of these dislocations, Sir A.
believed that out of twenty cases, twelve would be on the dor-
, five in the ischiatic notch, two in the foramen ovale, and one
ubes.†

UAL DISLOCATIONS.—Besides the above four varieties, a dis-
directly downwards on the tuberosity of the ischium; one
backwards on the spine of the ischium; and one directly up-
n the space between the anterior spinous processes of the ilium,
en known to occur, although very rarely. In a case of disloca-
ctly downwards, recorded by Mr. Keate, the limb was length-

ication forwards. From Sir A. Cooper.

e dislocations generally happen to adults. In very old people it is
mmon for the cervix femoris to give way. They are also rarely met
children—although Sir A. Cooper relates one case which happened to a
ven; Mr. Travers, jun., one to a boy of five; and the late Mr. Place,
orne, was good enough to communicate to the author the particulars
of dislocation on the dorsum ilii happening to a boy of ten.

ened three inches and a half, and was fixed and everted; the trochanter was sunk; and the head of the bone, close to and on a level with the tuberosity of the ischium, where it was capable of being moved under the finger. In a case of dislocation on the spine of the ischium, which happened in the practice of Mr. Earle, at St. Bartholomew's, the limb was lengthened about half an inch; it was neither everted nor inverted, but if anything the latter: there seemed to be a great vacuity in front of the hip; the edges of the sartorius and tensor vaginæ femoris could be plainly felt, and a cavity behind them; and the trochanter was further back, and not so prominent as usual. But the dislocation directly upwards is the most common of these unusual forms. In a case that was examined by Mr. Travers, jun., some time after the accident, the limb was completely everted and slightly moveable; and the neck of the bone lay between the two anterior spinous processes of the ilium; so that when the patient was erect, the limb seemed to be slung or suspended from this point. The diagnosis must in such cases be guided by an attentive examination of the deformity that is present, and by the absence of any symptoms of fracture. The reduction must be effected by extension, made in such a direction as seems most likely to bring the head of the bone into its socket.*

IX. DISLOCATIONS OF THE KNEE.—Dislocation of the *tibia from the femur* is not very common; and, when it does occur, is rarely complete. In most cases the tibia is thrown backwards towards the ham. The deformity and impediment to motion will enable the practitioner to distinguish the accident: the displacement must be rectified by simple extension, and the knee be kept at rest till inflammatory symptoms have subsided. There often remains a permanent inability to keep the joint firm in the straight position.

DISLOCATION OF THE PATELLA may occur either inwards or outwards; more frequently in the latter direction on account of the outward traction of the extensor muscles. The symptoms are, that the knee cannot be bent, and that the bone can be felt in its new situation. This dislocation may be caused either by mechanical violence, or by a sudden contraction of the extensors of the thigh. It mostly happens to knock-kneed, flabby people. There is, in general, no difficulty in reducing it by means of the finger and thumb, if the knee is straight and the leg raised. There is one variety of this dislocation, however, in which the patella is turned round on its long axis, so that its outer edge lies immediately under the skin, and its inner edge rests on the trochlea of the femur, where it is as firmly fixed as if screwed down. In one instance, the surgeon was unable to reduce it by any means, even although he divided the ligamentum patellæ, and cut through

* See a paper on Rare Dislocations of the Hip Joint, in the Med. Chir. Trans., vol. xx., by Mr. Travers, jun. Guy's Hosp. Rep., vol. i., Keate, Med. Gaz. vol. x.; a case of dislocation directly upwards, Lancet, May 15th, 1841; Mr. Earle's case, Lancet, vol. xi., p. 159; case of dislocation downwards and backwards (with dissection and drawing), by Mr. Wormald, Med. Gaz., 29th Jan., 1837.

the quadriceps at its insertion into the patella; and the patient died in seven months, in consequence of his wounding the joint. Mr. Mayo states a similar case, in which he succeeded in overcoming the difficulty by bending the knee to the utmost, so that the patella was drawn out of the groove in which it was lodged.*

The patella is dislocated upwards after rupture of its tendon by the extensor muscles. This must be treated as fracture of the patella; but it is very rare.

PARTIAL DISLOCATION OF THE SEMILUNAR CARTILAGES.—During sudden twists of the knee-joint, the semilunar cartilages may slip out of their proper position, and become wedged in between the tibia and femur. The symptoms are, sudden extreme sickening pain, and inability to stand, or to straighten the limb, with a depression on the side of the joint affected. This accident generally happens to people of relaxed habits, and when it has once happened is very liable to recur. In a case dissected by Mr. Fergusson, the external semilunar cartilage was found to be torn from its connexion with the tibia, except just at its extremities. The best way of restoring the part to its place, is to place the patient on the affected side, with the knee bent, and rotate the tibia gently in its axis. Should this not succeed, says Mr. Vincent, "the only thing is to keep the patient in bed, and in some of his slumbers all will come right" of itself. The patient should put on an elastic knee-cap before he moves about.

DISLOCATION OF THE HEAD OF THE FIBULA is of very unfrequent occurrence; except as a consequence of relaxation of the ligaments from weakness, which must be treated by cold douche, stimulating liniments, and bandages, with a pad to press on the head of the bone, or by rheumatic effusion into the joint cavity; to be treated by iodine paint, bark and iodide, &c., F. 94. There are two cases of it, caused by violence, in Sir Astley Cooper's work; the head of the bone could be felt to pass more backwards than natural, and could be moved by the finger. The pad of a tourniquet was employed to keep it in its place.

X. DISLOCATION OF THE ANKLE is generally caused by jumps from great heights or from carriages in motion, and may occur in four directions, each of which is usually complicated with fracture of tibia or fibula, or both. 1. Dislocation of the *tibia inwards* is the most common. It is attended with fracture of the lower third of the fibula, and may be easily known by the sole of the foot turning outwards; its inner edge turning downwards; and great projection of the internal malleolus. 2. Dislocation of the *tibia* and *fibula outwards* is attended with fracture of the internal malleolus, and may be known by the sole of the foot

* Three cases are related in Sir A. Cooper; and a similar one in Sir G. Ballingall's Military Surgery. Mr. Vincent says, that the obstinate resistance which this dislocation offers is owing to the fact that when the limb is straight, the extensor muscles, which are the retaining force, are in their position of strongest action; when the knee is bent they are in their weakest position. Op. cit. p. 74.

turning inwards. 3. In the dislocation *forwards*, the foot appears shortened, and the heel lengthened, and the toes pointed downwards. There is also a partial dislocation forwards, in which the tibia is only half displaced from its articulation with the astragalus, the fibula being also broken; the foot appears shortened and immoveable, and the heel cannot be brought to the ground. 4. A dislocation backwards has been described; but it must be excessively rare, as Sir A. Cooper never saw it. There is a case of it described by Mr. Colles, which, however, was probably one of transverse fracture of the tibia and fibula just above the joint, with displacement backwards. The fracture of the fibula about three inches above the outer malleolus, which accompanies the dislocation of the tibia, is commonly called Pott's fracture. As a fifth variety, may be quoted the thrusting up of the astragalus between the bones of the leg, as represented in the adjoining cut.

Treatment.—These injuries may be so various and complicated, that it is impossible to lay down particular rules for every variety, although

* Unreduced dislocation of the tibia inwards, with fracture of fibula; from a cast taken by Mr. Willmott, of St. Mary's Hospital, a year and a half after the accident. There was no attempt at reduction.

† Astragalus thrust up between tibia and fibula. Accident of five years' standing; no attempt had been made at reduction. There was no fracture. From a cast by Mr. Willmott.

the general principles are clear. Reduction must be effected as soon as possible, and for this purpose the patient may either be laid on the injured side, with the knee and hip bent, or on the back, with the thigh raised, and knee bent. Then, whilst an assistant steadies the knee, the surgeon must grasp the instep with one hand, and the heel with the other, and make extension (aided by pressure on the head of the tibia), till he has restored the natural shape of the parts. Then the limb must be put up with a splint on each side, in the same manner as a fracture of the lower part of the leg, taking care to keep the great toe in its proper line with the patella; and it may be *slung*, or may be put on its side, according to the judgment of the surgeon; and the starch bandage applied, after swelling has subsided, according to circumstances. Chloroform may be administered to render reduction more easy, and opium in regular doses afterwards, to prevent displacement by twitching and spasm.

COMPOUND DISLOCATION of the ankle-joint is by far the most frequent example of that kind of injury. If the wound in the integument does not heal by the first intention, the joint inflames; suppuration occurs in about five days; much of the cartilage is destroyed by ulceration; at last the wound is filled with granulations, and the patient recovers a tolerably good use of the foot in from two to twelve months. The first thing to be done is, to wash away all dirt with warm water; to remove any shattered pieces of bone gently with the fingers, and then to reduce the bone to its place; slightly enlarging the wound in the skin, if necessary, in order to effect this without violence. If it is very difficult to return the end of the tibia, or if it is fractured obliquely, or much shattered, or stript of periosteum, it is better to saw it off; as the patient will have quite as good use of the limb afterwards. Then the external wound should be closed with a bit of lint dipped in the patient's blood, or covered with collodion, and the leg be secured with a tailed bandage placed on a Macintyre splint, or two of Pott's side splints, if the situation of the wound will allow, and be wetted with an evaporating lotion. Care must be taken not to let the foot be pointed, nor be turned to either side. The remaining treatment is the same as that of compound fracture; and the rules which are given as to the necessity of amputation are the same in both cases.

XI. DISLOCATIONS OF THE FOOT.—The most important of these are the dislocations of the astragalus, which may be separated from its connexion with the os naviculare and os calcis in various ways. Sometimes it is thrown inwards, so as to rest on the inner surface of the os calcis; and in this case, there appears an unusual projection below the inner ankle, and a corresponding depression below the outer one, and the whole foot seems displaced outwards. Sometimes it is thrown outwards; and then the foot seems to be displaced inwards. If these dislocations are simple, reduction should be immediately attempted by extension, and chloroform will be needed; perhaps the pulleys, for the reduction is often a work of difficulty; but patience and good management will usually succeed. Chloroform and opium

ought to render unnecessary the proposal of dividing the tendons of refractory muscles, unless they intervene between the bone and its socket in such a way as to prevent replacement. If the dislocation is compound, and the bone cannot be replaced, or if it is much shattered, it may be dissected out. In these two dislocations, the astragalus is separated from the other tarsal bones, but preserves its connexions with the tibia and fibula, so that they may be regarded merely as varieties of dislocation of the ankle-joint, in which the tibia and fibula carry the astragalus with them in their displacement. It may, however, be completely shot out from under the tibia, and lie under the skin of the outer side of the foot. And lastly, it may in the same way be dislocated backwards; projecting behind the ankle-joint, and pushing the tendo Achillis backwards. This displacement, if only partial, it will be extremely difficult to rectify, and if complete, it will most likely be impossible.* If under these circumstances the dislocation be compound, the bone may be dissected out. The same may be done even in simple dislocation if the use of the foot can be thereby improved.

Besides these, the five anterior tarsal bones may be dislocated from the os calcis and astragalus. The cuneiform bones may be dislocated upwards from the navicular; the metatarsal bones from the tarsal, and the toes from the metatarsal. In any of these cases, the proper position of the parts must be restored as much as possible by pressure and extension, and be preserved by bandages; but reduction will often be very difficult, if not impossible.

CHAPTER VII.

INJURIES AND DISEASES OF ARTERIES.

SECTION I.—WOUNDS OF ARTERIES.

Symptoms.—An artery may be known to be wounded by the profuse spirting out of florid blood, *per saltum;* that is to say in jets, corresponding to the beats of the pulse, and indicating by their size that of the artery, or of the wound in it.

Pathology.—The bleeding from wounded arteries must necessarily be often profuse and dangerous, because from the nature of their coats, they do not collapse as the veins do; and because of the perpetual current of blood impelled by the heart.

* For cases of the dislocation of the astragalus backwards, see a paper by Mr. B. Phillips, Med. Gaz., vol. xiv., p. 596, and Fergusson's Practical Surgery. See also Mr. Cross's case of dislocation of astragalus reduced by dividing the tendo Achillis, quoted in Ranking, vol. ix., p. 140; Campbell de Morgan, B. Phillips, Lonsdale, and others, Lancet, 1849, vol. ii., p. 618. Henry Lee's case, in which the os calcis and the other bones of the foot were dislocated from the astragalus with the tibia, Lancet, 1852, vol. i., p. 313. Richard G. H. Butcher, of Dublin, on Fractures near the Ankle Joint; Dublin, 1852 (*objects to tenotomy as a means of facilitating reduction*).

But we find a provision in nature for avoiding this danger.

1. If an artery of small size, as the digital or the temporal, be cleanly cut across, there will be a pretty brisk hæmorrhage for a time; but it will soon cease, under the influence of the following natural processes.

First, the divided vessel *contracts*, so as to close its orifice; and so, also, as to lessen its canal immediately above, into the shape of the neck of a champagne bottle. If all goes on well, there is, secondly, the *exudation of fibrin* around the orifice; and thirdly, there is *coagulation* of the blood for a short distance within. The vessel also, fourthly, retracts into its sheath, if the surrounding tissues are loose enough to admit of it.

Under the influence of these four processes, the bleeding is checked; then if all goes on well, the contracted orifice is sealed up by the united lymph, and the coagulum within gradually becomes firmer, adheres to the walls of the vessel, loses its colour, fibrillates, and, in process of time, becomes organized into fibro-cellular tissue, forming, with the impervious end of the artery, a mere fibrous cord.

2. If a *very large* artery, such as the femoral or subclavian, is wounded, and if the aperture in it is large, and the flow of blood is in no manner opposed, the loss of blood will be so rapid as to occasion death almost instantaneously. If, however, the wound in the artery is very small, it may be closed firmly by coagulated blood during syncope, and the patient may survive if properly treated.

3. If the artery is of the second order, as the humeral or tibial, the bleeding will most probably cease for a time. But in the course of some hours, when the faintness has passed off, and the heart beats strongly again, the coagula in the orifice of the vessel will most probably be dislodged, and the bleeding will recur again and again, so that the patient will very likely die of it, unless it be checked by art. In some cases, however, the orifice of the vessel may become permanently closed.

4. A *puncture or partial division* of an artery may be much more troublesome than complete division; because the chief process for arresting hæmorrhage, namely, the *contraction*, is prevented; and the bleeding can only be obstructed by the coagulated blood in the wound. Under these circumstances, three things may happen. In the first place, the aperture, if longitudinal or very small, may in favourable cases be closed by adhesion, the artery remaining pervious. The uniting lymph, however, is very liable to be dilated into a *false aneurism*. An oblique cut is likely to bleed most obstinately. Or, secondly, the channel of the artery may be obliterated by coagulated blood. Or, thirdly, bleeding may recur perpetually, till the patient dies, or the undivided part of the vessel ulcerates, or is divided by art. From these details may easily be gathered the reason why, when a small artery has been partially divided (as the temporal in arteriotomy), it is judicious to divide it completely.

When an artery *is torn across*, it contracts almost immediately, and

becomes quite impervious, so that an arm or leg may be torn off by a shot or by machinery, without any loss of blood from the axillary or

tibial arteries. For this reason, there is no hæmorrhage from the umbilical cord of young animals, which is either torn, or bitten through by the mother. Lastly, it will be readily seen that division of arteries which are diseased, or which are situated in condensed and inflamed tissues, so that they cannot contract or retract, will be followed by profuse bleeding. Hence it is, that after secondary amputation, in which the parts divided are condensed from inflammation, bleeding is much more copious, and many more ligatures are required, than after primary amputation.

Treatment.—The first indication is to stop the flow of blood. For this purpose, if the wound is a small one, and there is bone underneath, as in the hand, forearm, or temple, the surgeon may make firm pressure on it with his thumb or finger: if the wound is wide and deep, he should poke his forefinger into it, wipe away all clots, and press with the point of the finger on the exact spot the blood issues from; or he may seize the bleeding orifice with his finger and thumb: in other cases, the blood may be checked by grasping the limb above, and pressing the main artery against the bone, with the points of the thumbs or fingers; or by applying the *tourniquet*;† or in default of that, by passing a handkerchief round the limb, with a stone twisted in it over the artery, and twisting it tightly with a stick. Immediate danger being averted by these means, the surgeon will probably apply a ligature.

Ligature.—When a stout thread is tied tightly around an artery, it divides the middle and internal coats, leaving the external or cellular coat enclosed in the knot.

If the student makes the experiment, and unties the knot, and slits up the artery, he will see the results shown in the next cut.

Then in the living body, the following series of phenomena occurs. The cut edges of the internal coats unite by adhesion, and the blood between the point tied and the nearest collateral branch coagulates and adheres to the lining membrane: and so the canal is sealed up. Meanwhile, the ring of the cellular coat enclosed in the ligature ulcerates; the ligature comes away in from five to twenty-one days (sooner or later, according to the size of the vessel), and, finally, that portion of the artery, which is filled with coagulum, shrinks into a fibrous cord.

* Contracted artery from umbilical cord of a calf.

† The tourniquet is described in the Chapter on Amputations.

The success of the operation will be promoted by using a small round ligature (of brown hempen thread), so as to divide the internal coats of the vessel smoothly, and by taking care to disturb it as little as possible from the surrounding parts which supply it with blood. If the place of ligature can be selected, it is better not to have it too near below the point where a large branch is given off, in order that the vessel may be sealed by a good coagulum before the ligature is separated; but this is of no great consequence.*

When, however, the artery is *diseased* and *brittle*, the ligature should be large, and not tied too tightly; otherwise it may cut through entirely; or else a small portion of the adjoining tissue must be included in the knot.

The manner of tying an artery is simple enough. If the orifice projects a little, as it does from the surface of muscles divided in amputation, it should be taken hold of with a forceps, and be gently drawn out, and then an assistant should tie a ligature round it as tightly and smoothly as possible in a double knot. If the bleeding orifice cannot be drawn out with the forceps, it may be transfixed with the *tenaculum*; but in some cases, where it is deeply seated or cannot be found, or is contained in a dense, consolidated tissue, it may be necessary to pass a curved *needle and ligature* through a considerable thickness of the flesh, and tie it up altogether. This was the practice usually adopted by surgeons of the last century; and is well called by John Bell, *groping* or *diving* with the needle. In all cases, however, where it is possible, the artery alone should be included in the ligature. After tying, one end of the ligature should be cut off, not too close to the knot, and the other be made to hang out of the wound. Assalini's spring forceps, and the little wire forceps, or *serrefines*, are useful when there is a lack of assistants.

When an artery is completely divided, it is necessary to tie both orifices; and if it is wounded, but not divided, a ligature must be placed by an aneurism-needle both immediately below and above the wounded part. It is necessary to observe, that in all cases, when it is possible, *a wounded artery must be tied at the wounded part*; and not in the trunk above.

But here the question may be asked, Supposing that there is a wound of an artery situated at a great depth under muscles; or that the wound is in an inflamed or sloughy state; so that the adjacent parts are so infiltrated with blood that it must be extremely difficult to find the wounded vessel—would it not answer the purpose to tie

* J. F. D. Jones, M.D., Treatise on Hæmorrhage and the Ligature, Lond. 1806; Porter on Aneurism.

the main trunk of the limb at some place between the wound and the heart, where it can be done easily—just, in fact, as an aneurism is treated?

The answer is, Certainly not:—the artery should be secured by two ligatures, one immediately above, and one immediately below the wound; and should not be tied in the trunk above: and the reasons for this rule must be evident enough from the following considerations. 1. A trunk may be tied that has no connection with the branch wounded. Thus, in wounds of the upper part of the neck, the trunk of the common carotid has been tied many times when the bleeding vessel has been the *vertebral*. 2. There is the possibility of high division, or some other unusual distribution of the arteries. 3. The limb below must be supplied with blood, by collateral circulation, else it will mortify. "But whenever," to use Mr. Guthrie's words, "this collateral circulation is sufficient to maintain the life of the limb, blood must pass into the artery below the wound, and must, as a general rule, pass up and out through the lower end of the divided artery." 4. Gangrene is very liable to follow if a ligature be placed high up in the thigh, in consequence of a wound. 5. The lower end of a wounded artery is not so quickly and effectually closed by a natural process of cure, as the upper, and is exceedingly liable to yield to the blood that regurgitates into it from below, and to bleed again and again until closed by ligature.

Wherever, therefore, an artery may be wounded, it should be secured at the wounded part, *if practicable*. We say *if practicable*, because in any case, if a man cannot do the best thing, he must do the best he can.* This will usually be to tie the artery ascertained to be the wounded one as near as possible to the bleeding point; and to repeat this process at the distal side, if bleeding occurs from that end. (See p. 334.)

* The rule of practice is well shown by a case which occurred to Mr. Butcher, of Dublin. A man was deeply stabbed in the right thigh by a knife; profuse and almost fatal hæmorrhage ensued, which ceased, but after thirteen hours returned; the wound 1½ inch long, in the long axis of the limb, a little above its middle, right over the sheath of the femoral artery, which was laid bare by it. The artery above being compressed, Mr. Butcher passed his left forefinger into the wound, but could not touch the bottom of it. Then he dilated it upwards and downwards for at least three inches. This allowed him to pass his forefinger still more deeply along the course of the wound, *far behind the femoral artery*, which lay between the finger and the bone. The tourniquet being slackened, up came a gush of scarlet blood from the *very deepest* part of the wound. The forefinger being now passed still more deeply in the track of the wound, entered a kind of tendinous slit. This was enlarged, yet the finger could not reach the bleeding point, though the wound was deep enough to bury the fingers and part of the hand. The patient being almost dead, and the least movement or the shifting of the tourniquet impracticable, Mr. Butcher at once secured the common femoral, below Poupart's ligament, by a transverse incision. This checked further bleeding, but the patient died of exhaustion twenty-four hours from the accident. A *p. m.* showed that the knife had sliced off a portion of the tube of the profunda artery, immediately behind the upper margin of the adductor longus tendon.—On Wounds of Arteries, by Richard G. H. Butcher, Dublin Quarterly Journ. Med. Sc., Aug. 1854.

When the wound in the skin is not sufficiently gaping to expose the bleeding part, the finger or a bougie should be first passed down as a guide to it, and then it should be laid open by a sufficiently long incision upwards and downwards. But if it is clear that a vessel is wounded by a stab from the remote side of the limb (as if the femoral is pierced by a wound at the back of the thigh), a bougie may be passed in, as before, as a guide for the incisions, but the operator may lay the vessel bare at the side where it is most easily accessible.*

Acupressure.—Great as are the advantages of the ligature over the searing irons which preceded them, yet it has some disadvantages; and in order to escape these, a process termed *acupressure* has been proposed by the fertile and ingenious mind of Professor Simpson. The disadvantages of the ligature are, 1st, that being composed of porous and decomposable materials, it is liable to become saturated with putrescent matters, and act as a seton of the worst kind; 2ndly, it of necessity causes sloughing, more or less, of the tissues encircled in the knot; 3rdly, it is sometimes most tedious in coming away. It may be remembered that Lord Nelson was ill for weeks through a ligature applied after the amputation of his arm, which did not come away. Thus ligatures keep open wounds for long periods, and render them, whilst open, prone to those states of decomposition which result in low inflammation and pyæmia. Professor Simpson proposes, 1st, to employ metallic instead of textile substances; 2ndly, to use them in such a way as allows them to be removed at will, so soon as the occlusion of the artery is complete, which may be at the end of 48, 60, or 120 hours, according to the size of the vessel. The method of employing *simple acupressure* is by passing a long needle through one of the flaps of a wound, in such a way that it shall compress the bleeding artery, just, says Professor Simpson, as we do the stalk of a flower when we fasten it into the lapel of our coat with a pin. The engravings show what is meant better than description. Fig. *a* shows the outer surface of a flap, with the needle passed through it; fig. *b* shows the mouth of the artery on the wound-surface of the flap, bridged over and compressed. The needle, which must be from 3 to 6 inches

Fig. *a*.

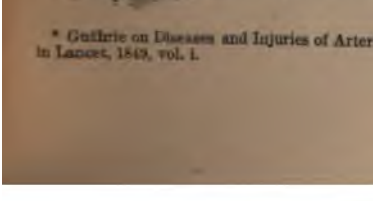
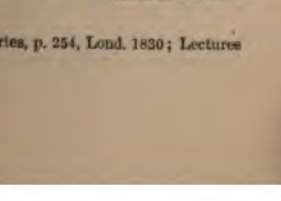


Fig. *b*.



* Guthrie on Diseases and Injuries of Arteries, p. 254, Lond. 1830; Lectures in Lancet, 1849, vol. i.

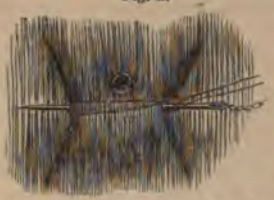
in length, according to the thickness of the wound, may in some cases be made to compress the vessel against a bone.

In the second method of acupressure, a small sewing-needle is employed, threaded with a short piece of *dead* or inelastic iron wire, by which it may be pulled out at pleasure. This is dipped down into the tissues on one side, then raised up, and made to bridge over the vessel, which is meanwhile compressed with the point of the left forefinger.

Fig. *c*.

In the third method, the sewing-needle is passed simply behind the vessel, and a noose of fine iron wire passed over the point, brought over the track of the vessel tightly enough to close it, and then secured with a slight twist round the stem of the eye-end of the needle. Whenever the operator chooses, he can pull out the needle, and then the wire loop follows without resistance. The wire passed through the needle should be distinguished by being twisted, or in some other way.*

Fig. *d*.



Other methods of checking the bleeding from arteries are,

1. *Torsion* is performed by drawing out the vessel, fixing it by a pair of forceps a quarter of an inch from the end, and then twisting the end round and round till it will not untwist itself. There is no English authority for applying this method to large arteries, but it may be useful enough when many minor vessels bleed after the extirpation of a tumour.

2. *Pressure* is a means of suppressing hæmorrhage that may be resorted to either when the ligature is deemed unnecessary, or when it cannot be applied. Thus it is applicable to wounded arteries of small size situated immediately over bones—as the temporal or occipital; or to arteries that cannot be tied, because they lie very deeply—as the vertebral or pudic after lithotomy; or to arteries that are so diseased that a ligature will not hold. The pressure must be confined as much as possible to the bleeding orifice, and should be effected by a *graduated compress*; *i. e.*, one composed of several pieces gradually decreasing in size, the smallest being on the wound. It is also a good plan to apply pressure to the course of the trunk above the wound. Moreover, when pressure is to be relied upon, the whole limb, including the fingers or

* For fuller information, see Professor Simpson's original Papers in the Med. Times and Gaz., January, 1864.

tion, should be accurately bandaged from its extremity, in order to diminish its entire circulation, and it should be placed in a raised position. When the palmar arch is wounded, one compress may be placed on the wound, and another on the back of the hand; a paper-knife or strong slip of wood may then be laid on each compress transversely across the hand, and their ends be firmly tied together. In some cases it will be impossible to apply compression in any other way than by the fingers of the operator and his assistants, relieving each other at regular intervals till bleeding ceases. This is termed "digital compression," and has often saved valuable lives.

3. *Cold* (especially sponging with iced water, or covering the bleeding part with ice in bladders) is applicable to cases of bleeding from numerous small vessels.

4. *Styptics* are of various kinds. 1. Some of them check hæmorrhage, by opposing a mechanical obstacle to the exit of blood—as the spatic, and other porous substances which entangle it; 2, others act by coagulating the blood; or 3, by causing contraction of the bleeding vessels; or 4, by exciting the adhesive inflammation and formation of granulations. The tincture or solution of perchloride of iron; a saturated solution of alum; turpentine, creosote, the nitrate of silver, and the *matico* leaf, are the best. They are applicable to the same cases as cold and pressure; that is, when the bleeding vessels are very numerous and small. The *actual cautery*, which is the most potent styptic of all, has two operations. If the iron be *red hot*, it stops bleeding mechanically, by burning up the orifices of the vessels; but the bleeding is liable to return when the eschar separates. It is better, therefore, to use the iron at a *black heat*, for it then excites the adhesive inflammation; and is very efficacious for arteries that either cannot be tied, or that are too diseased to hold the ligature. A *pinch with the forceps* will often cause small vessels to cease bleeding. Many obstinate hæmorrhages from small vessels cease when the wound is cleared of coagulum, and the bleeding part exposed to the air, or sluiced with iced water, and bound up again.

5. *Medical Treatment.*—In cases of arterial hæmorrhage, which there is any difficulty in restraining by ligature or otherwise, it will be necessary to keep the patient in the recumbent posture, and to tranquillize the heart's action by opium. The diet should consist of milk, broth, and other substances that nourish without stimulating.

Supposing that so great a loss of blood has taken place as to endanger the patient's life, the head must be kept low: beef-tea with brandy be given frequently by spoonfuls, and opium in small doses every three or four hours.

It has been recommended in extreme cases to apply a tourniquet to each of the unaffected limbs, with a view of retaining in them as much blood as possible. In a desperate case, where life would evidently be lost without it, *transfusion* should be resorted to. See Part V. Chapter II.

SECTION II.—SECONDARY HÆMORRHAGE.

SECONDARY HÆMORRHAGE may be defined to be that which comes on after the lapse of a few hours, or later, after an injury. There are several varieties.

1. It often happens that in a few hours after a wound has been bound up, and the patient put to bed and become warm, sundry small arteries bleed. This case is easily managed. The wound must be opened; any vessels must be tied that require it; the surface be sponged with cold water, and then be exposed to the air for a few hours.

2. A second variety is that which has been so ably described by Mr. Guthrie,* and which occurs when a wound of the femoral artery is treated like an aneurism, by tying the vessel at a distance, instead of tying it immediately above and immediately below the wound. Mr. Guthrie lays down the following propositions, viz., That although any artery in the *upper* extremity may be tied anywhere with very little risk of gangrene, yet that gangrene of the foot and leg often follow, when a ligature has been placed high upon the femoral artery, in consequence of a wound. This is not the case when the ligature is applied for an aneurism, because then the collateral circulation has had time to enlarge before the operation. But if after ligature of the femoral, the collateral circulation is sufficient to maintain the life of the limb, the blood will pass into the large arteries below the part tied. Then if there be nothing to hinder it, the blood will escape from the lower orifice of the wounded artery.

Mr. Guthrie shows also that the processes by which the ends of a divided artery are healed, are less perfect in the lower end than in the upper. The artery does not contract so much, neither does it retract, neither is there a perfect internal coagulum, neither is there an exudation of such plastic lymph. Hence when blood begins to pass into the lower part of the vessel through the collateral circulation, the wounded part gives way to the pressure.

The characteristics of this kind of hæmorrhage are, that the blood (to quote from Mr. Guthrie) "is of a venous colour, and flows or wells out in a continuous stream, as water rises from a spring, and not with an arterial impulse." It may come on at almost any interval till the wound is healed.

The prevention of this accident will consist in observing Mr. Guthrie's rule, to tie every wounded artery both above and below the wounded part, if practicable. If hæmorrhage does occur, the vessel should be cut down upon and secured. Nevertheless, in no case, says Mr. Guthrie, should an operation be done on a wounded artery unless it bleeds. For if it does not bleed, rest and pressure may avert the necessity of any operation at all. But on this point, see p. 147.

* Commentaries on Military Surgery, 6th ed., p. 190 et seq.

3. There may be a *general oozing* of blood from a wound, owing to some disorder of the general health, such as malarious fever in hot climates. Its *causes* and *treatment* are described in the Chapters on Hæmorrhage and Gunshot Wounds, p. 146. The surgeon must recollect its liability to occur in the female from the menstrual issue.

4. Hæmorrhage may occur from *sloughing* or from *ulceration* of an artery; or from imperfect closure of an artery when a ligature separates; through the influence of some diseased state of the artery or of the constitution, which has prevented the healthy process of adhesion. This form of hæmorrhage will be more likely to occur if the ligature was coarse, thick, and ill applied, so as to bruise the internal coats instead of cutting them evenly; or if the artery was much disturbed in its sheath during the operation. In such a case the only remedy is to cut down upon and tie the bleeding orifice; or, if that cannot be done, or the vessel be too diseased to hold the ligature, carefully-graduated pressure and stypties may be tried. A small button of lint, imbued with turpentine or with solution of perchloride of iron, may be put on the bleeding point (or the latter may be touched with a black-hot iron first), over that a larger compress, and so on, till firm pressure can be produced. Should all these measures fail, the trunk must be tied above at the nearest point to the wound that is possible.

In the case of hæmorrhage from an artery laid open by hospital gangrene or phagedæna, the actual cautery, with the free application of nitric acid, turpentine, or bromine, and pressure, are the best remedies.

SECTION III.—DIFFUSED AND TRAUMATIC ANEURYSM, AND ANEURYSMAL VARIX.

1. DIFFUSED ANEURYSM.—When an artery has been lacerated, by a broken bone, for instance, without a wound of the skin, or when an artery has been stabbed, and the wound in the skin has healed, but that in the vessel remains open, so that the blood escapes into the cellular tissue, a *diffused aneurysm* is said to be formed. But this term is not at all descriptive of the real state of things, and is very liable to lead the young practitioner into the error of treating the case as if it were a real aneurysm. The fact is, that a real aneurysm has a *sac*; the diffused aneurysm has none. Hence the escape of blood from the wounded part may be unlimited. A true aneurysm may, however, become diffused by its sac being burst by a blow or giving way under the pressure of the forces of circulation.

The *symptoms* are, a dark-coloured swelling of the limb; perhaps fluctuating; perhaps yielding some degree of pulsatory thrill, if the aperture in the artery is large; and most probably, if a main trunk is wounded, there will be coldness, numbness, absence of pulsation, and tendency to gangrene in the parts below. The case must not be treated as if it were an aneurysm, by a ligature high up; but the main artery being compressed with the fingers, the swelling must be laid open, the blood removed, and the wounded part of the artery secured by two

ligatures, one immediately above, the other just below it. The whole field of surgery does not present a more difficult operation, nor one requiring greater judgment, nerve, and dexterity.* This is a case, in which, as John Bell well said, boldness is better than caution. "Run your bistoury upwards and downwards, so as to slit up the tumour quickly; plunge your hand suddenly down towards the bottom; turn out the great clots of blood with your fingers, till having reached the bottom entirely, *you begin to feel the warm jet of blood*; and directed by that, clap your finger upon the wounded point of the artery; as it has but a point your finger will cover it fairly, and your feeling the beating of the artery assures you that all is now safe."† After the operation, considerable suppuration, perhaps sloughing of the sac and parts infiltrated ensues. This must be treated on general principles.

It is possible that a diffused aneurysm may be mistaken for a rapidly-growing cancer. A man may meet with a blow on the thigh, causing pain and swelling. The swelling does not subside: on the contrary, it continues slowly to increase; evidently infiltrates the whole tissues of the limb; is somewhat elastic, perhaps displays feeble pulsation at parts; punctured with a grooved needle yields serum or blood. The case is supposed to be *malignant*, and amputation hopeless; the patient sinks. After death there is found no cancer, but a great collection of blood, fluid or coagulated, amongst all the deep muscles, and proceeding from a small artery that had been ruptured by the blow. An incision would have revealed the mystery.

II. The FALSE or TRAUMATIC aneurysm is said to exist when the lymph, by which a puncture in an artery has been united, yields to the pressure of the blood, and dilates into a sac. If the puncture in the artery be small and the blood be slowly effused under a strongly resisting fascia or aponeurosis, a sac may be gradually formed by condensation of the enveloping tissues, and a false aneurysm be the result. This is

* In addition to the numerous capital cases illustrative of these doctrines which are to be found in Mr. Guthrie's Commentaries, a very ably and fairly reported case, which occurred in the practice of Mr. Henry Smith (Med. Times, June 23rd, 1855), well deserves perusal. An old man met with a punctured wound at the upper part of the right thigh; arterial bleeding followed, but soon ceased. A tumour formed, occupying the whole of the front of the upper part of the thigh; it was circumscribed, pulsating, and communicating a thrill to the ear. Its pulsation was controlled by pressing the external iliac artery; the popliteal beat freely. Arterial haemorrhage returned on the seventh day. Mr. Smith being summoned, most correctly diagnosed a wound of some artery, probably the profunda, not the femoral. *The external iliac artery was tied.* Everything went on well for a month, although the original wound sloughed. The ligature came away, and the wound of the operation healed; but on the thirty-fifth day from the operation, and forty-second from the injury, the original wound bled again. *It bled again profusely on the fifty-ninth and sixty-third day (from the injury)*; and on the last-mentioned day Mr. Smith again operated, by enlarging the original wound, and at a great depth, and under circumstances of great difficulty, securing the vessel originally wounded, which was either the profunda or external circumflex. In another month the patient was well.

† John Bell, Discourses on Nature and Cure of Wounds, Edinburgh, 1870, vol. i., p. 75.

to be treated, like the last case, by two ligatures; one immediately above, the other below the wounded part, if careful compression fails to effect a cure.

III. ANEURYSMAL VARIX is produced when an artery is punctured through a vein (the brachial artery through the median basilic vein at the bend of the elbow, for instance), and they adhere together, the communication between them remaining permanent. The consequence is, that blood passes from the artery into the vein at each beat of the pulse, causing it to become enlarged and tortuous, and to present a vibrating thrill at each pulse.

IV. VARICOSE ANEURYSM is said to exist when an artery has also been punctured through a vein, and a false aneurysm has formed between them, opening into both, and formed of lymph that was effused between them. The difference between *aneurysmal varix* and *varicose aneurysm* (which is a cause of perplexity to young students) is this: aneurysmal *varix* is a swelling of a vein, caused by the admission of arterial blood into it. Varicose *aneurysm* is the same thing, but with the addition of a false aneurysm, situated between the artery and vein. These two cases need not be interfered with unless they enlarge rapidly, or cause inconvenience. If they do, and *flexion* fail (p. 348), a ligature must be placed both above and below the wounded part of the artery.

SECTION IV.—THE HÆMORRHAGIC DIATHESIS.

THE HÆMORRHAGIC DIATHESIS is a peculiar constitutional defect, which seems to consist in a want of contractility of the arteries, and of coagulability of the blood; so that the slightest wound bleeds almost uncontrollably, and life may be lost through the most trifling injury or surgical operation. If the existence of this diathesis be ascertained, surgeons would do well to refrain from operations with the knife on the individual possessing it. In a case of congenital phymosis, in a person of this kind, which fell under Mr. Liston's care, he very judiciously employed the ligature instead of the knife. This diathesis often runs in families. Thus the history is recorded of four children who were born of healthy parents: their skins were white and complexions fair; they were very subject to fever with ecchymosis; their blood was very fluid, but coagulated in the usual manner; violent coughing easily produced hæmoptysis or epistaxis, and any slight injury caused ecchymosis of the skin. One died at twenty months from biting his tongue; another at eight years from general mucous hæmorrhage; and a third at twelve from epistaxis. In a case of obstinate bleeding of this kind, pressure and the nitrate of silver, matico, or tannin, locally, and a nutritious diet, with tincture of the muriate of iron or the acetate of lead and opium, or gallic acid, or turpentine in very small doses, F. 74, seem to be the most hopeful remedies. Of course in such cases as these it would be a great absurdity to tie an arterial trunk at a distance, though the mistake has been committed.*

* Vide Brit. and For. Med. Rev., Jan. 1840; and two valuable papers by Dr.

SECTION V.—DEGENERATION AND INFLAMMATION OF ARTERIES.*

I. DEGENERATION of the arteries is a very common affection in advanced life, and is the cause not only of rupture, dilatation, and aneurysm, but probably of the dry gangrene of the aged, of softening of the brain, and of apoplexy. The first step in the process, in the larger arteries, seems to be thickening of the innermost coat in patches of variable size by an interstitial deposit of fibrine. The next step seems to be, the fatty degeneration of this fibrine into a so-called *atheromatous* or pappy mass, which, examined microscopically, is seen to consist of oil-globules, cholesterine, amorphous fragments, and earthy crystals. Then the fibrous coat becomes thin and loses its structural character, and also undergoes fatty degeneration; the elastic fibres being separated and replaced by fat, and losing their curling properties: meanwhile the outer or cellular coat becomes thickened and vascular, as if from chronic inflammation.

Instead of the fatty degeneration, the fibrine and coats of the vessel may undergo the calcareous or ossific; producing specks, or rings, or projecting spicula of calcareous or bony matter, or even converting the vessel into a rigid earthen tube.

In the smaller vessels, especially of the brain, the middle coat loses its structural marks, and becomes studded with oil-globules or with earthy particles.

II. ACUTE ARTERITIS AND EMBOLISM.—The cases described under this name were probably cases of *embolism*. From the venous system clots may be transported *to* the *right* side of the heart, and block the pulmonary arteries wholly or partially; if wholly, causing sudden death; if partially, producing gangrene, or "inflammation" of a portion of lung. The occurrence of pneumonia after wounds and operations is thus easily accounted for. Conversely on the left side of the heart, portions of fibrine, detached from its walls, may find their way into the arteries, and may be arrested in, and block them up, stopping off the current of the blood, and giving rise to very serious consequences; for instance, to softening of the brain, if either of the cerebral arteries should be the seat of obstruction; or to the disorganization of the organ supplied by smaller arteries; or, again, to the production of pyæmia through the disintegration of the separated fibrine, and the admixture of its decomposing particles with the blood.†

Allan of the Haslar Hospital, and Mr. Miller of Edinburgh, in Dr. Cormack's Journal for June and July, 1842. The stout porter of the St. George's, Hanover Square, workhouse, Mount Street, has this diathesis.

* Guthrie, op. cit.; Mayo, Pathol., p. 447; Copland, Dict., *Art.* Arteries; Hodgson on Diseases of Arteries, Lond. 1815, p. 5; Gulliver, M. C. T. xxv; Brodie's Lectures; Edward Crisp on the Structure, Diseases, and Injuries of the Blood-vessels, Lond. 1847; Descriptive Catalogue of Pathological Specimens, in Museum of Royal Coll. of Surgeons, vol. iii.

† W. Senhouse Kirkes, M.D., on Detachment of Fibrinous Deposits, &c. Med. Chir. Trans., vol. xxxv. Cohn, über Embolischen Krankheiten; also Med. Times, 1862.

When a large artery is blocked, the *symptoms*, which formerly were ascribed to arteritis, are, tenderness and swelling of the affected artery, violent pain and numbness and tendency to gangrene in the parts supplied by it. The author some time since treated a young man for dysentery; and, during convalescence, the axillary artery in the last part of its course suddenly became swelled and painful, and the hand cold, with no pulse. The patient was treated with small doses of mercury, and the circulation was completely restored in three weeks. Dr. Crisp relates several cases of far greater severity. A girl, aged 22, suffered from violent fever, fainting, profuse perspirations, great pain in the limbs, and tenderness in the course of the arteries. After some days, no pulse could be felt in the axillary from an inch below the clavicle, or in the popliteal. Both feet became gangrenous, especially the left, which was amputated below the knee eight months afterwards: at the time of the operation no pulse could be felt in any of the extremities. Very little blood came from the larger arteries, and that not *per saltum*, but the smaller vessels bled profusely. On examination of the leg, the arteries seemed smaller than natural, but not otherwise diseased. In another case, the patient died with rheumatism and diseased heart; the brachial artery was enlarged and plugged with fibrine. In the dry gangrene of the aged, the main artery sometimes, but not always, contains solid fibrine. In a case, recorded in the Provincial Medical Journal, 23rd April, 1842, sudden obliteration of the left axillary artery, with intense pain and numbness of the arm, and sloughing of the end of one finger, followed the hæmorrhage of abortion in a young lady of 24.

SECTION VI.—ANEURYSM.

Definition.—An aneurysm is a pulsating tumour formed by a sac filled with blood coagula, and fibrinous laminæ, and communicating with an artery, by the rupture or dilatation of which it has been produced.

Varieties.—In the first place, a distinction must be made between aneurysm, which consists of a dilatation of an artery, for a *part only* of its circumference; and the *general dilatation*, which consists of a bulbous expansion of all the arterial tunics for the whole of their circumference, and which differs from true aneurysm in containing no *laminated fibrine* or *coagula*.

The *true* aneurysm consists of a sac formed by one or more of the arterial tunics. The *false* and diffused aneurysms, so called, which result from wounds of arteries, have been described in the 3rd section of this chapter. Besides these kinds, authors speak of a *sacculated* aneurysm; that is, one which is formed into pouches by an unequal dilatation of its parietes; and of a *dissecting* aneurysm, that is to say, one in which the blood finds its way between the arterial tunics, and may even open into the artery at another part.

Pathology.—Aneurysm generally commences by a giving way of the

internal and middle coats of the artery at the site of some atheromatous spot, after which the pressure of the blood dilates the external or cellular coat into a pouch. This mode of origin is evident from the distinct, rounded, circumscribed opening by which most aneurysms communicate with the artery. It may also commence by a dilatation of all three of the tunics at some diseased spot. Sometimes the wound of the inner and middle coats produced by a ligature has produced aneurysm at the part tied.† Sometimes, again, as in a case that happened to Mr. Liston, an artery ulcerates and opens into a contiguous abscess, the sac of which becomes the sac of the aneurysm. Let the aneurysm, however, begin as it may, it gradually dilates under the constant pressure of the heart's impulse. It soon becomes lined with coagula, deposited in distinct concentric laminæ, of which the outer ones are the palest and firmest; and whether it was originally formed of all the three tunics or not, certain it is, that the inner two soon waste and disappear, and cannot usually be traced far from the opening into the artery.

Symptoms.— If an aneurysm be seated in the neck or limbs, it appears as a tumour in the course of an artery, and pulsating with it. By the stethoscope, a blowing sound or bruit will probably be heard at each pulsation. If it be small, and not filled with coagulum, pressure on the artery above will render it flaccid, and it may be emptied by further pressure; and the blood returns into it afterwards with a peculiar vibratory thrill. The patient will very often say that it commenced after some violent strain, when something appeared to give way. The first thing usually felt is a pulsation; then a tumour, not painful at first, but gradually becoming excessively so from its pressure as it enlarges. The neuralgic pain, caused by the stretching of nerves by an increasing aneurysm, is often most excruciating. In the chest, aneurysm will be principally known by an unnatural pulsation felt by the patient, and detectable by the stethoscope; together with symp-

* An incipient aneurysm of the arch of the aorta. The portion of artery represented is slit up, so as to show the cut edges, with the atheromatous deposit between the coats of the vessel.

† Paul Broca, *Sur les Anévrysmes*, Paris, 1856, p. 41.

toms of disordered circulation and respiration. In the abdomen, an aneurysmal tumour may be felt through the parietes.

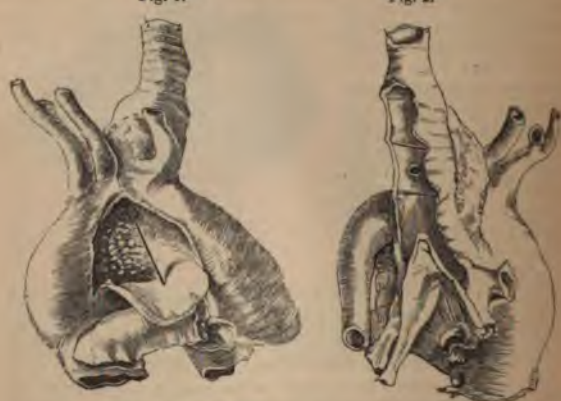
Diagnosis.—Other tumours situated over arteries, and receiving contiguous pulsation from them, may be distinguished from aneurysm by noticing, 1st. That they do not pulsate at first, when they are small; whereas aneurysms do so from their earliest formation. 2ndly. That a tumour may often be lifted up from the artery, and that then it will cease to pulsate. 3rdly. That aneurysms are generally soft at first, and become hard subsequently; tumours are generally the reverse. 4thly. That tumours *cannot be emptied by pressure;* and that no alteration is made in their size or consistence by compressing the artery above. 5thly. *Enlarged lobes of the thyroid gland* may be distinguished from aneurysm of the carotid by their slipping up out of the fingers, along with the larynx, in the act of deglutition. 6thly. *Psoas abscess* may be known from aneurysm by the precursory pain and weakness in the back; and by its disappearance when the patient lies down. 7thly. Pulsating tumours composed of *erectile* or of *cancerous growths*—especially those connected with bone—are sometimes mistaken for aneurysms; from which, in fact, it may be hardly possible to distinguish them during life, since they may have the same kind of pulsation, attended with the same whizzing noise, and checked, like that of aneurysm, by pressure on the artery above. The mistake, however, is of

* This drawing exhibits an aneurysm of the common femoral artery, for which the external iliac was tied by Sir B. Brodie. The ligature is seen imbedded in lymph; the coagulum in the artery above and below it; and the laminated coagula in the aneurysm. From the Museum of St. George's Hospital.

no very serious consequence, because the ligature of the main artery, which would cure an aneurysm, might check the growth of a tumour. 8thly. The contiguous impulse of a tumour in contact with an artery is *in one and the same direction in all its parts*, whereas, in an aneurysm it is an impulse radiating in all directions from a common centre, a *dilating impulse*. This may be demonstrated by placing the ends of two quills or lead pencils on opposite sides of the tumour. If the impulse be a true dilating impulse the pencils will *diverge* from each other, but not by a contiguous impulse.

Progress.—As an aneurysm enlarges, its coats become thinner, but are strengthened by the adhesion of the parts around. As the enlargement proceeds, these are gradually absorbed; bone offers no resistance, but is absorbed as well; and at last the tumour reaches the skin and distends it. Inflammation succeeds; the skin becomes red, then livid and vesicated; and sloughs. When the edge of the slough separates, a fatal bleeding ensues; sometimes in a gush enough to destroy life at once, although more frequently the blood oozes away slowly. But an aneurysm may open into a mucous canal; or into a serous cavity; or into a vein, with, of course, a fatal disturbance of the circulation if the vein is large; or into the cellular tissue of a limb; or it may cause death through its pressure on the trachea or œsophagus; or through the pain and irritation created by its compressing nerves or interfering with the abdominal viscera, without bursting. We may observe, that when an aneurysm opens into a mucous canal (as shown in the following figure), it is usually by a small round ulcerated spot, not by a slough,

Fig. 1.* Fig. 2.



* Figure 1 exhibits a front, and Fig. 2 a back view of an aneurysm of the arch of the aorta, which burst into the trachea. From Mr. Lane's Museum.

as in the skin; when it bursts into a serous cavity, it is generally by a crack or fissure.

Causes.—The *predisposing* cause of aneurysm is some pre-existing degeneration of the arteries. The *exciting cause* may be, strong emotion of the mind, violent exertion of the body, or local injury. Men are very much more subject to it than women; and it is especially a disease of middle life, being most frequent between the ages of thirty and fifty, although Mr. Syme has met with it in children of seven and eight.

Situation.—The most favourite situation of aneurysms is in the aorta, near the heart; but if aneurysms of the aorta are excluded from our consideration (since they are not to be relieved by any surgical interference), we shall find that, of all the arteries of the limbs, the popliteal is the most frequently affected. Thus, out of 179 cases of spontaneous aneurysm collected by Lisfranc (not including any of the aorta), there were 59 of the popliteal artery; 26 of the femoral in the groin; and 18 in the femoral at other parts; 16 of the carotid; 16 of the subclavian; 14 of the axillary; 5 of the external iliac; 4 of the innominata; 3 of the brachial, common iliac, and anterior tibial, respectively; 2 of the gluteal, internal iliac, and temporal, respectively; and 1 of the ulnar, perinæal, internal carotid, radial, and palmar arch, respectively.

Dissecting Aneurysm.—This variety of aneurysm begins with ulceration of the lining membrane of an artery at some diseased spot, in such a way that the blood penetrates between the arterial tunics, splitting them up, and making false passages between them. In this way very anomalous symptoms may be produced, of which no better example can be desired than is afforded by a case of Dr. Todd's, related in the 27th volume of the Med. Chir. Transactions. In this case, ulceration had taken place in the aorta, and this was the starting-point of a splitting up of the middle arterial tunic, which extended upwards through the innominata into the right carotid, and partly into the left, and downwards nearly as low as the kidneys. The getting in of the blood between the coats of the arteries stopped the circulation through the proper canal of the vessels; and caused softening of the anterior portion of the right hemisphere of the brain by depriving it of its supply of blood; besides suppression of urine, and other symptoms that would have been almost inexplicable, unless a post-mortem examination had been performed.

Spontaneous Cure.—Every aneurysm does not pursue the fatal course we have described, but in a small number of cases a spontaneous cure is produced. 1st. The most natural and obvious, although unhappily a very infrequent mode of cure, occurs, when a laminated coagulum lines the sac, in sufficient quantity to resist further dilatation; or conversely, when the propulsion of blood into the tumour is so languid as to allow of the formation and solidification of that clot. And here we must observe that a distinction is to be made between an *active* and a *passive* clot. The *active* consists solely of fibrine slowly deposited from

the blood on the unnatural surface, and tending to become organized and to remain permanently as a false membrane, and to check the disease; and the formation of this is promoted, as we have just said, by everything that renders the circulation at that point *languid*, without stopping it altogether. The *passive* clot, on the contrary, is a mass of coagulated blood, such as may be produced by cutting off any quantity of blood from the circulation, as in ecchymosis; and this, as we have shown (see *Ecchymosis*), is rarely susceptible of becoming organized, but usually is dissolved and absorbed: or not seldom gives rise to suppuration and is discharged. Yet a *second* mode of spontaneous cure is sometimes found to be caused by violent inflammation or abscess, in which the aneurysm and artery are involved; so that the blood in the sac is made to coagulate, and the artery obstructed by the coagulum. 3rdly. It has happened, in a few lucky cases, that a portion of clot has been detached from the interior of the sac by some accidental violence, and has effected a cure by blocking up the opening into the aneurysm, or by *embolism* in the main trunk of the artery itself below the aneurysm. 4thly. The artery has become obliterated by an accidental pressure of the aneurysm upon it, above or below the opening of communication, under the resisting tension of a strong aponeurosis; or by the pressure of blood escaping from it on its bursting into the cellular tissue.

Treatment.—The indications are to imitate the natural modes of cure, and especially the first.

1. *By Compression.* This very simple and obvious mode of treatment was employed long since by Guattani and others, and with some degree of success; but it was usually applied *immediately* on the aneurysm itself, and was both imperfect and violent, so that it more frequently failed than succeeded, and often caused considerable mischief. During the last few years, however, it has been revived by the Dublin surgeons, Hutton, Cusack, and Bellingham, and has been rendered so safe, painless, and speedy a remedy, that it ought to supersede the ligature in popliteal aneurysm, and, in fact, in any case whatever in which it can be applied. And it is used *mediately;* that is, on the sound artery between the aneurysm and the heart; and in such a way as to retard the circulation and so cause an *active* clot; not to stop it suddenly, and so produce a passive clot.

The instrument employed to cause the pressure, may be either Signoroni's tourniquet (shown in the sketch, p. 347)—an arc of steel, with a joint in the middle, and a screw by which the extremities of the instrument are pressed together; or else a solid clamp of steel, having a wooden splint at one end, and a pad with a screw at the other. But as these are liable to slip, Carte's circular tourniquet, which envelopes the whole pelvis firmly, and in which the severity of the pressure is mitigated by India-rubber bands, is the favourite instrument at present. In some cases a common four-pound weight may be placed over the artery in the groin, with a pad intervening; or the pressure may be effected by the fingers.

The *advantages* of compression are, that it can be discontinued in a moment should it appear expedient; and that there is no chance of that

severe and frequent accident of the ligature—secondary hæmorrhage: and that should it fail, the knife can still be resorted to, without deterioration or disadvantage in the condition of the parts.

The *objections* which have been urged against it are, that in some cases the patient, from irritability of system, cannot bear it for a sufficient length of time to produce a cure; and that inflammation and sloughing of the integuments may ensue, especially if there is a debility of the circulation, and a want of vitality in the skin.

Compression is *contraindicated* when the integuments are inflamed, or the limb much swelled from venous obstruction; and likewise in cases which are very rapidly increasing, with little tendency to the formation of fibrinous layers, for there is always a danger of the tumour bursting, or of the limb below becoming mortified. In such cases the ligature must be applied. And if, *during* the course of treatment by pressure, such circumstances should suddenly arise, it must be at once remitted, and immediate recourse had to ligature of the vessel above.

The patient, before undergoing this treatment, should be purged, and during it he must be confined to bed; the excretions by stool and urine be kept up by aperients and salines; the diet nourishing but not stimulating; and pain and restlessness be allayed by opium. The skin at the part pressed should be shaved, if necessary, and be well powdered with French chalk. The pressure should not be severe enough to cause great pain; and it should be applied at two or three points, in the course of the femoral artery; being shifted, when it becomes irksome, from one to another. It should not be carried to the point of completely closing the vessel; its most beneficial operation being that of obstructing or lessening the flow of blood so as to relieve the interior of the aneurysm from the force of the heart's impulse and to keep the vessel

at rest by limiting its diastole. This may be left to the patient himself, if intelligent and made acquainted with the exact object of the process; but he must be cautioned of the danger of sloughing from too violent compression. It may generally be left off at night. If the case goes on favourably, the aneurysm is, after a time, found to have lost its pulsation, and to have become solid. This happy event may occur in three or six days, or perhaps may require as many weeks; after which the tumour wastes slowly, and the limb may be brought into use again.

In cases which do not admit of pressure being applied *mediately*, it may be tried cautiously on the tumour itself, or upon the artery below it. Cases are recorded which give room for hope from such measures.*

2. *Continued Flexion* was first proposed by Mr. Ernest Hart, and is one of those simple, common-sense methods which really are more difficult to hit upon than many complex and elaborate ones. The limb must be bandaged well, and evenly, from foot to thigh; the patient be quieted by opiates, and the knee-joint (if it be a popliteal aneurysm) gradually bent, and kept so. Thus the artery being bent transversely at right angles, has its calibre diminished. Digital compression may be used as an aid. This plan was first tried in this country by Mr. Hart in 1858; then by Mr. Shaw, of the Middlesex Hospital; Spence, of Edinburgh; Pemberton, Durham; and many others.†

3. *By Ligature.*—In cases in which the above plans are inapplicable or unavailing, the artery must be tied between the aneurysm and the heart. The operation, it is generally taught, according to Hunter, should be performed neither too near the aneurysm, so as to place the ligature on a portion of the vessel that is diseased, nor too far from it, lest the circulation through it be kept up too freely, by means of collateral branches. After the operation, the temperature of the limb falls two or three degrees; but in a few hours it rises rather higher than that of the opposite limb, because the blood is forced to circulate through the superficial capillaries. Subsequently it sinks again rather below the natural standard. Therefore the patient should be placed in bed, with his limb in an easy position; wrapped up in cotton wool, to preserve its circulation; and though it become rather swelled (which is not unlikely), cold must on no account be applied.

After the operation the limb may become gangrenous. If the gangrene spread beyond the fingers or toes, amputation should be performed at the level of the ligature.

Brasdor's operation.—When a ligature cannot be applied—as in aneurysm of the carotid, innominata, or subclavian—between the

* For the earlier cases, see Dr. O. B. Bellingham, Dublin Journal, May 1841; Greatrex and Robinson, M. C. T., vol. xxviii.; Carte, Dublin, Med. Press, May 16, 1849; case of axillary aneurism cured by compression on the distal side, by Dr. M. Goldsmith, of America, ib.; for the later, Bellingham, Med. Chir. Trans., xxxiv.; and cases by Tuffnell, Cock, B. Phillips, and others, in Ranking, vol. xvii. For a summary of objections see Mr. Syme's Contributions.

† See Hart in Med. Chir. Trans. vol. xlii.; also Med. Times, 1862, vol. i. p. 145; also report of paper read at Med. Chir. Soc. Dec. 8, 1863; Med. Times, 1863, vol. ii. p. 657.

aneurysm and the heart, it has been proposed to tie the vessel on the distal side; and this operation has been performed with success in cases of carotid aneurysm, by Mr. Wardrop and others.

Syme's operation.—For such cases, Mr. Syme, whose vigour and fearlessness as a surgeon are above all praise, has revived the old operation of direct ligature which Hunter caused to be discarded in favour the distant ligature. This is in effect the same as the operation for traumatic aneurysm, so vividly described by John Bell, and quoted at p. 338. Mr. Syme lays open the aneurysm, scoops out the blood, and seizes and ties the artery just above and below its orifice into the aneurysm. But it may be said, How is the patient to be hindered from bleeding to death whilst this is done? With great sagacity, Mr. Syme made an incision along the outer edge of the sterno-mastoid muscle (it was an axillary aneurysm), through the platysma and fascia, so as to allow his assistant's finger to be pushed down and compress the artery where it issues from under the scalenus articus, and lies on the first rib. This mode of commanding arteries in complicated operations is well worthy of note. Thirty years ago, in a case in which troublesome hæmorrhage was apprehended during removal of the upper jaw-bone, Mr. Syme made an incision between the ramus of the lower jaw and mastoid process, so as to have enabled a finger, if need be, to have been thrust in to compress the internal maxillary artery.*

4. *Fergusson's Treatment by Manipulation.*—In two cases of aneurysm of the right subclavian artery, between the scaleni, Mr. Fergusson instead of trying the hopeless operation of ligature between the tumour and the heart, or the very doubtful one of ligature on the distal side, endeavoured to block up the artery, by fibrine squeezed from the sac. He first emptied the sac by pressure with his thumb, then deliberately squeezed and rubbed the opposed surfaces against each other, so as to force some of the fibrine into the artery. The effect in each case was immediate and striking. In the first case there was giddiness, in the second partial hemiplegia, rendering it probable that some particles of fibrine had been carried up to the brain; in the first, after one or two repetitions of the manipulation, all circulation in the vessel and its branches below was arrested, and the tumour became smaller and firmer. Nevertheless after some considerable exertion, it burst into the brachial plexus, and the patient died seven months after the first manipulation. In the second case (in which, by the way, all pulsation had ceased in the arteries below for some months before the manipulation) the tumour became gradually less, and the man was alive and well two years afterwards.

5. Various modes of cure have been from time to time proposed on the principle of causing *coagulation of the blood in the sac*. The most hopeful of these, is the injection of a solution of basic perchloride of iron, of the strength from 15 to 20 degrees of Beaumé's Areometer, by means of a syringe, the fine nozzle of which is made with a cutting point, so as to puncture the sac. The piston is

* Syme, Med. Chir. Trans. vol. xliii.

depressed by a screw, each turn of which causes one drop of liqu exude; and during the operation, the artery should be compr above, and the tumour be gently handled, so as to mix the perchl with the blood as rapidly as possible. If it succeeds, the tumo converted into a solid mass, and a little serum only exudes fro puncture.*

6. *Medical Treatment.*—In cases in which an operation is impo the great object is to keep the circulation tranquil, without reducin strength. The nervous system should be tranquillized by opiu tobacco-smoking. Small *bleedings* may be performed in some if the patient is plethoric, and the tumour increases rapidly, violent pulsation; but it should never be carried to faintness. The should be light and unstimulating, but highly nutritious to dispo the formation of plastic fibrine. With the same view the admini tion of the acid salts of iron, especially the perchloride, is much recommended. *Bodily* or *mental excitement* should be rigidly abst from. *Digitalis* and *tartar-emetic* are of questionable propriety. *acetate of lead*, F. 75, is said to have the faculty of rendering the coagulable, and of diminishing the calibre of the arteries. It used mentioned in terms of commendation by Mr. Green, in his lectur King's College, who gave some instances of its efficacy.† But it be recollected that *frequent bleeding* and too *rigid starvation* increase the irritability of the heart and arteries, and diminish plasticity of the blood. Particular care should be taken not t minister drastic purgatives; because they invariably cause a excitement and throbbing of the arteries.

SECTION VII.—VASCULAR TUMOURS.

The VASCULAR TUMOUR (*Nævus, Erectile Tumour, Telang tasis*) consists, *anatomically*, of enlarged and dilated blood-vessels. seems to consist in an overgrowth of these organs, and may capillaries, arteries, or veins, together or separately. In a great cases of infantile origin it is very superficial, consisting of a mer patch of dilated capillaries (*mother's marks or stains* with little elevation above the surrounding skin). In most cases there is a of dilated capillaries, inextricably packed together; and on a sec the great dilatation of the vessels, and the small quantity of interv tissue, causes them to resemble a collection of cells rather than of t

* For an account of the older plans of causing coagulation, such as Home's heated needle, the introduction of threads, and galvano-punctur South's Chelius, vol. ii. See also M. Pravaz's plan of injecting the pervh of iron, Lancet, 1853, vol. i. p. 561; Fergusson's Surgery, 3rd ed., p. 638; op. cit.

Mr. Moore, of the Middlesex Hospital, has lately tried the plan of p many yards of very thin iron wire into an aneurysm of the innominata; coagulation took place, but the patient died.

† See also a case of aneurysm of aorta cured by acetate of lead in doses, Arch. Gen. de Med., Sept. 1839; see Mr. Fergusson's papers, Med. Trans., vol. xl.

In some instances the arterial character predominates; the tumour, if situated in the skin, being of a vivid scarlet, and pulsating strongly; in others, it is of a most dusky hue and venous character. In some instances, again, the affection seems to be confined to the larger blood-vessels, with little, if any, implication of the smaller ones. If the arteries are affected (as shown in the following figure), the tumour (which is sometimes designated *aneurysm by anastomosis*) is tense and pulsates vividly; if the veins, they feel like a bunch of earth-worms, and are easily emptied.

The most frequent *situations* are the skin, and subcutaneous cellular tissue, especially about the head. It has been found in bone. The causes are unknown. The disease is usually congenital. The vulgar idea is, that a lobster, or raspberry, or some such thing has been longed

for by the mother, and that the influence of her mind has impressed on the fœtus the image of the thing she longed for. It may originate, however, later in life.

Symptoms.—Nævus of the skin may present itself as a mere red speck or patch, or as a soft raised swelling, dusky or scarlet, according as it is arterial or venous. The subcutaneous nævus feels soft, and very much like a fatty tumour, except that firm pressure will usually cause it to be emptied and to disappear. "Some of these tumours," says Mr. Liston, "communicate a thrill to the fingers; they can be emptied to a certain extent, by uniform and continued pressure, or by interrupting the circulation, and are instantly filled on permitting the blood again to flow into or towards them. The large ones pulsate synchronous with the heart's action. They are much increased in size by anything that increases the activity of the circulation; as the cries of children, and the violent exertion of adults. On the application of the stethoscope, pulsation is heard as in common aneurysmal tumours, and

a sound which differs from that of the common aneurysm, being lo rough, and whizzing, and which being once heard can never be n taken."

Diagnosis.—These tumours are distinguished from fatty growths the signs which have just been described; and from vascular canc by their long continuance without deranging the health.

Consequences.—The author has seen many cases of congenital v cular tumours waste spontaneously during the first few months years of life, and give no further trouble. In other instances t increase to a certain size, and then become stationary, or waste, leavi perhaps, certain cysts containing blood or a reddish serum, as remains of cells and pouches formed by distended vessels. In ot cases, again, they increase rapidly, invade every adjoining tiss ulcerate or slough at the most prominent parts; and so may dest life by hæmorrhage, or keep it in constant danger. The tumour c posed of dilated veins is a very different thing from varix, inasmuc it spreads in a manner showing it to be quite uninfluenced by weight of the column of blood. In one patient the author has see cluster of dilated veins, the size of a walnut, under the skin of the of the leg. This has been stationary since birth. In another case middle-aged woman, the author has seen this condition begin and ext rapidly from under the heel, up the calf of the leg to the ham. Th was a great hypertrophy of skin, and under it, large clusters of dila veins.

Treatment.—The cure of these diseases may be effected—1, by m sures which retard the circulation through the enlarged vessels; which cause the blood to coagulate, or which excite the adhesive infla mation, and so obliterate or disorganize the distended vessels; or, by extirpation with the ligature or knife. The former class of reme is best adapted for nævi under the skin, the latter for those which plicate the skin itself.

Of the former class the best remedy is the *seton*; and the best w of using it is to pass several threads with a common sewing-needle different directions across the tumour, withdraw them so soon as t have excited suppuration, and then pass others through other parts the tumour. If a larger needle is used, it should be straight and f with sharp edges, and should be made to drag as much silk as it possibly carry, so as to fill the wound, and prevent hæmorrha Some surgeons dip the threads in croton oil, or in a solution of lu caustic, but this seems unnecessary. On a similar principle the na may be *punctured* with the point of a lancet, and a fine probe wh has been dipped in melted nitrate of silver, or a needle heated t black heat, may be passed through it in various directions, or M shall's galvanic cautery may be employed for this purpose; or its s stance may be simply broken up with a cataract-needle. *Pressure* means of a smooth surface of ivory or sheet-lead, confined by strip plaster and a bandage, is a good remedy, if the nævus is small s situated over a bone, so that it can be applied uniformly and st

tually. Mr. Fergusson sometimes passes a needle under a small nævus, and twists a thread over it, so as to cause considerable pressure, allowing it to remain for forty-eight hours or longer, after the manner used for the relief of varicose veins. *Congelation*, after Dr. James Arnott's method, will sometimes check the growth of a nævus. The injection of an astringent fluid, by means of Anel's syringe, was proposed some time since, and a solution of sulphate of zinc, so employed, caused the patient's death by convulsions. The obvious conditions necessary for the safety of this plan are—that the liquid employed shall not be poisonous in itself; that it shall be capable of at once curdling the blood, so that there may be no chance of its being diffused through the circulation; and that it shall not cause abscess or render the clot incapable of being afterwards absorbed with safety. The neutral solution of perchloride of iron, recommended by Pravaz, may be employed; but experiments are wanting to decide upon the substance most suitable. Probably a solution of matico or some astringent vegetable might answer. Mr. Haynes Walton has used a solution of *tannin* with success in a case of nævus of the orbit. The solution of perchloride of iron has been used with success by Mr. W. Adams in a case of traumatic aneurysm; and Dr. Brainard, of Illinois, has published a case in which, after ligature of the common carotid had failed, he produced a cure of a rapidly-increasing nævus of the orbit by injecting a solution of 8 grains of lactate of iron in a fluid drachm of water. *Vaccination* has also been used for this disease; but it requires that the whole surface of the tumour and some of the skin around should be inoculated, so as to cover it with a confluent vesicle, which excites great *fever*; and the opportunity of doing so must be rare. A very small nævus may also be destroyed by touching it with a glass pen dipped in *nitric acid:* this is also a good method of removing little red spots on the face, formed by a distended vessel with radiating branches; but immediately after applying the acid, the part should be sponged with a solution of carbonate of soda, to prevent too wide a destruction of the skin, and consequent scar.

The *tumour composed of dilated veins* is best treated by subcutaneous incision, so as to divide it in several places, and by continued bandaging. If small, and not growing, it should not be meddled with.

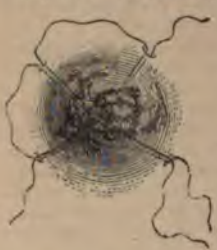
Extirpation of these tumours by the knife is advisable only when they are of the cutaneous variety, or when they can be lifted up from the parts beneath, so that their whole extent can be ascertained. Two elliptical incisions should be made, to include the whole of the diseased growth, and a little of the sound tissues around. For, to use Mr. Guthrie's words, "it cannot be too forcibly impressed on the mind of the surgeon, that if the diseased part be cut *into*, the bleeding will be terrible and difficult to stop."

But it is generally considered that the *ligature* is the safest and best method. With this proviso, that *skin* should not be included in a ligature and allowed to ulcerate; but that it should either be dissected back

in flaps from the tumour, before the latter is tied; or that, if this is not done, a cut should be made through the skin for the ligatures to lie in; —or that the ligatures should be passed under the skin, so as to strangulate the morbid growth, and leave the skin untouched.

One mode is to pass two or three needles crucially through the base of the tumour, and then twist a strong twine ligature firmly round beneath them.

Or, two or more double ligatures may be passed through the base of the tumour, with a curved needle which has its eye at its pointed extremity and then the tumour may be strangulated by tying the adjacent threads together.



Or, the knot devised by Mr. Fergusson, represented in the adjoining figure, may be used. A double thread is carried by a stout long suture needle, with a large eye, transversely under the centre of the tumour, and divided in the middle. Next, the disengaged end of the thread is passed through the eye of the needle along with the one already occupying it, and, having been brought one-fourth round the circumference of the tumour, is passed through its base transversely to the first. Lastly, the adjoining ends of the two threads are to be tied tightly, so that each of the two threads shall include an 8-shaped portion of the tumour. The tumour may be punctured before the threads are finally tightened; and in every case the constriction should be made as tight as possible. After two or three days the ligatures should be tightened, or fresh ones should be applied. In each of these cases the skin should be cut through just before the threads are tightened, so as to make a chink for them to lie in, and to avoid the pain and delay of ulceration through the skin.

A somewhat similar and entire strangulation of the tumour, when it affects the skin, is accomplished by Mr. Wood in the following manner. A needle mounted on a handle with a slight curve only in the blade, and a piece of stout, smooth, hempen ligature, well soaped and then oiled, are used in this operation.

First, the needle, armed, is passed diagonally across the base of, and under the nævus, the loop of the thread caught and left in the puncture, and the needle withdrawn. Then the needle, carrying the long end of the thread, is again passed across the base of the nævus at right angles to the former, the loop again retained, and the needle finally disengaged. Care must be taken in doing this part of the proceeding to have the free end of the thread travelling through the needle's eye, so as to leave it disengaged when withdrawn. Then four curved incisions are made passing from one puncture to the other through the skin only. The loops are then drawn upon so as to sink the thread well into the incision opposite to them (see fig. 1). Then

the ends of the thread are each passed through the loop of its own side, drawn tightly through the punctures, and tied in a loop knot or bunch

Fig. 1.

Fig. 2.

so that they can be unloosed and retightened as the tissues shrink and ulcerate under the pressure.

In four or five days, the strangulated parts are sloughy and more or less separated. If not the ligature must be tightened upon them. As the wound fills by granulations, these must be carefully watched, and any tendency to nævous growth (marked by a deeper redness than the healthy granulations) must be restrained by the application of strong nitric acid, laid on with a feather, the parts being afterwards well oiled.

Another method, practised by Mr. Wood in cases where it is desirable to save the skin and prevent a scar, as in subcutaneous nævi of the face, neck, hands, and arms, is done as follows:—The same needle is used as in the operation last described. Armed with a stout, hempen, well-soaped ligature thread, it is first passed under the skin round half the circumference of the morbid tissue, entering and emerging at the opposite poles of the tumour. The short end of the thread is left in the puncture, and the needle withdrawn, carrying the long end. Next, it is passed under the base of the tumour across its diameter, entering and emerging at the punctures first made. The loop at the eye of the needle is then caught, and held while the needle is withdrawn, carrying the free end of the thread. Lastly, the needle is passed round the remaining half of the circumference, under the skin, through the same two punctures, and the ligature thread detached.

There are now a loop and two free ends emerging from the further

puncture, the thread being entirely sunk into the puncture nearest to the operator, as seen in the adjoining figure (see fig. 2). The ends are then each made to pass through the loop, and tied very tightly in a loop knot, so as to leave the power of tightening it as the parts inclosed shrink under the ulcerative process. As the thread is tightened, the loop recedes into the puncture, but is held there by the ends passing through it, and the pressure exercised throughout is

everywhere equalized. By this method the suppuration and sloughs formed by the nævus escape by the two punctures along with the thread. Two small spots of cicatrix remain the only evidence of the operation having been done.

A method analogous to extirpation is, the *division of all the soft parts around the tumour*. This was once done successfully by Mr. Lawrence, in an aneurysm by anastomosis on the finger. He divided all the soft parts, except the tendons and theca. But in other cases it has been unavailing.

If the disease is inaccessible to any of these means (as in the orbit) and increases rapidly, ligature of the common carotid (or of whatever other large vascular trunk supplies it) is the only resource.

The figure in the preceding page represents a case of this disease, chiefly of a venous character, in a female, about thirty years of age. Mr. Storks tied the common carotid artery, with the effect of producing

a marked decrease in the tumour; and the patient having been subsequently admitted into the King's College Hospital, under the care of Mr. Fergusson, the remaining tumour was successfully treated with the needle and ligature, employed as for the cure of varicose veins.*

CHAPTER VIII.

INJURIES AND DISEASES OF VEINS.

SECTION I.—WOUNDS OF VEINS.

THE HÆMORRHAGE from wounded veins is not in general dangerous, unless from some large and deep-seated trunk, in which valves are not present, or from a large varicose vein on the leg, in which the valves are impaired. It may in ordinary cases be restrained by pressure and a raised position. But if there is any difficulty in the matter, it will be necessary either to apply a ligature or to keep up unremitting pressure on the bleeding point with the finger. The latter practice was resorted to "in the case of his Excellency William Prince of Orange, who, in his hurt by the Spanish boy, as my Lord Bacon relates, when the internal jugular was opened, could find no way to stop the flux of blood, till the orifice of the wound was hard compressed by men's thumbs, succeeding for their ease one after the other, for the space of forty-eight hours, when it was hereby stanched."†

SECTION II.—INFLAMMATION OF VEINS, OR PHLEBITIS.

The veins seem to be not particularly susceptible of inflammation; nor does that inflammation, if unaccompanied by the admixture of decomposing fluids with the circulation, seem to be particularly noxious; on the other hand, decomposing fluids, introduced into the circulation through a wounded vein, will very readily cause death, without any inflammation of the vein by which they entered. Still less without any affection of the vein spreading towards the heart, as used to be supposed. Hence *Pyæmia* may exist without phlebitis, and phlebitis may exist without it.

1. *Veins not prone to inflame.*—That the lining membrane of veins

* Vide Curling's Pathological Lectures in Med. Gaz., July, 1838; Lawrence, Med. Chir. Trans. ix. 216; a fatal case of convulsion during the operation for nævus by injection, Med. Gaz. vol. xxi., p. 529; J. Adair Laurie on Cricoid Aneurysm, Med. Gaz., 21st Oct., 1842. The author has also borrowed from a lecture which he heard delivered by Sir. B. Brodie, at St. George's Hospital, in Nov., 1842, as well as from many clinical remarks of Mr. Fergusson's after operations in the King's College Hospital. See also Birkett, Med. Chir. Trans., vol. xxx.; Paget, Lectures on Surgical Pathology, vol. ii.; Brainard, Lancet, Aug. 20, 1853; Mr. Adams's case, Lancet, 3rd Sept. 1853; Haynes Walton, Ophthalmic Surgery (*On Nævus near to Orbit*).

† Turner, op. cit., vol. i., p. 316.

6. *Idiopathic Phlebitis.*—This is not a very common disorder. The author has, however, treated a few cases, such as the following:—1. A woman, æt. thirty: several superficial veins on the outer part of left thigh, swollen and tender; skin over them red; blood in some parts coagulated; no constitutional symptoms. 2. A girl, æt. nineteen: complained of severe pain in right knee. On examination, the pain was referred to the ham and upper part of the calf, which were swollen and tender; and there was tenderness and redness of the saphena, up the thigh; the tongue loaded; headache, thirst, and nausea. Rest, purgatives, and fomentations are the remedies for such cases; the origin of which is probably to be found in some impurity of the blood.

7. *Traumatic Phlebitis.*—When a vein is wounded, and the wound is not accurately closed, or when it is disturbed, so as to break up the commencing adhesions, and allow pus or decomposing sanies to find its way into the vessel, the first effect should be, as we have just said, the coagulation of the blood. Even then, if the blood be healthy, the part be kept at rest, and the intruding liquid small in quantity and not very noxious, no greater harm need ensue than some swelling and inflammation around the vein. But under more unfavourable conditions, the blood in the affected vein will coagulate widely (*thrombosis*); parts of the clot soften into puriform fluid; the cellular tissue in the track of the vein suppurate; the skin redden; and the vein become first thickened from infiltration, then softened, and broken down, so as to allow the clots contained to mix with the abscess around it. This process will be accompanied with considerable pain and fever; but not with pyæmia if the blood has coagulated firmly and widely enough. The *morbid anatomy* is very simple. The vein is thickened, and reddened wherever its inner surface has been in contact with clot; and it contains coagulated blood, which in the focus of the disease is decolorized, and softened into puriform fluid.

Treatment.—From the foregoing details some useful practical hints may be extracted; for instance, the expediency of the most accurate closure of all wounded veins; the great use of those old-fashioned so-called *vulnerary balsams*, such as the *Friar's Balsam*, or of the application of brandy, or collodion, or similar substances, to wounds, so as to seal them up from the atmosphere, and produce firm coagulation of the blood; the necessity of rest after a wound, so as not to disturb the coagula; the danger of great loss of blood, and of too low a diet (especially after parturition), which might render the blood incapable of firm coagulation; the fact that the abscesses about inflamed veins are truly eliminative and salutary in their character; and the questionable utility of cold lotions, leeches, and mercury, to diminish the local inflammation, which probably, as Mr. Lee remarks, is the means adopted by nature to prevent general infection of the blood. The remedial measures, then, are rest, warm fomentations, and poultices; early incision of abscesses; evacuation of bile and fæces, by one or two doses of calomel; opium, to relieve pain, and insure quiet of mind and body; and wine, especially if there has been great loss of blood.

SECTION III.—VARICOSE VEINS AND PHLEBOLITES

I. VARIX signifies an enlarged and tortuous state of the veins, which are generally thickened, rigid, and divided into irregular pouches, with their valves incapable of preventing the reflux of blood. This state is usually said to be caused by anything that retards the venous circulation; such as occupations that require a standing posture; or pressure from loaded bowels or the gravid uterus. But there must be some other cause, because varix often occurs when there is no pressure on the veins to account for it; and if produced by temporary pressure in healthy people, it subsides of itself when that pressure is removed; a fact that is familiar to practitioners in midwifery. Moreover it may exist to a great extent without causing much inconvenience; and in other cases, a very small amount of it may produce very serious evils; such as pain, soreness, aching. Hence the writer believes that in many cases the blood is primarily at fault, and that a gouty condition of this fluid, with tendency to stagnation, precedes the distension of the vein. It is most frequently *seated* in the lower extremities, scrotum, and rectum.

Varicose veins on the leg produce several troublesome consequences. 1. In the first place, they occasion great pain, weight, and fatigue upon taking much exercise, or remaining long in an erect posture. 2. They frequently cause ulcers or excoriation of the skin. 3. Sometimes a vein becomes exceedingly thin, and bursts, causing a profuse or even fatal hæmorrhage, inasmuch as there may be no valves between the part ruptured and the heart. 4. Occasional clotting of the blood occurs in the affected vein, with inflammation; which may perhaps give rise to abscess.

Treatment.—This may either be *palliative* or *radical*. The palliative consists of measures adapted to prevent further enlargement, and induce contraction of the distended veins. If one or two trunks only are affected, it may be sufficient to apply pieces of leather spread with soap-plaster firmly over them; but if many smaller veins are enlarged, the whole limb should be well supported with a calico or caoutchouc bandage, or laced stocking, which should be applied in the morning, before the patient rises. Friction with a flesh-brush is strongly recommended by Mr. Vincent; but in all cases the friction should be in the course of the blood, not against it, so as not to strain the already weakened valves. Galvanism may be of service. When the patient is not taking exercise, the leg should be placed in a raised position. But the author would call attention to the little-noticed fact, of the great aggravation of pain, weight, and swelling of the affected part, produced by inactivity of the bowels and kidneys, and of the great relief obtainable by purgatives, antiarthritic medicines, and tonics.

But if these means fail, and the patient is subject to urgent inconvenience, the radical cure must be resorted to; that is to say, the diseased veins must be obliterated: a proceeding which will have some

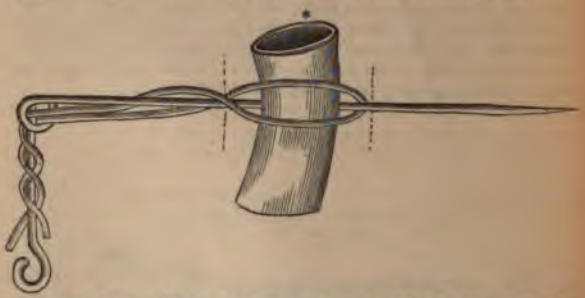
prospect of success if only one or two large trunks are affected; but not if all the minor cutaneous veins are enlarged also. There are several ways of effecting this. 1st. Some years ago Sir B. Brodie recommended division of the vein by *subcutaneous section*, in the following way. A long, curved, narrow-pointed knife, like a bistoury, but cutting on the convex edge, was introduced by the side of the vein, and carried horizontally with its flat surface between it and the skin. Then the convex edge was turned towards the vein, in order to cut through it, as the knife was withdrawn. 2ndly. Mr. Watson, of New York, recommended, in some cases, *excision* of a portion of the affected vein. Then, 3ndly, there is a method which was introduced by Mr. Cartwright, and improved by Mr. Mayo, of destroying a narrow slip of skin across the vein by a paste of *potassa fusa* and quicklime, in order to cause slight inflammation of the vein, with coagulation of the blood in it, and obliteration of its cavity. 4thly. *Pressure* by means of a firm pad and bandage may be used for the same purpose.

5thly. The *twisted suture*. The surgeon pinches up the vein between his left forefinger and thumb, and passes a needle behind it: it is a good plan also to pass another at right angles, which should be made to transfix the vein twice, and should go behind the first; a thread is then to be twisted around them tightly enough to stop the circulation; and this may be done at as many places as the surgeon thinks requisite. The points of the needles should be cut off. They should be allowed to remain till the blood in the vein is solidified, or until they have produced slight ulceration. 6thly, Mr. H. Lee has adopted with good effect a subcutaneous section of the affected vein, at a part between two of the needles.

In varicocele and varicose veins, Mr. Wood has employed with great success a plan by which the inclusion of skin as well as of the vein in the ligature, and, consequently, much pain and soreness is avoided. A piece of small iron wire and a peculiarly formed pin are employed.

The pin is straight at the point, and spear-shaped, like a hare-lip pin. At the other end it is bent into a right angle, upon which a loop is twisted, terminating in another round loop for convenience of handling

and fastening. First, a common curved suture needle, armed with thread, is passed fairly under and across the vein. The end of the thread is then fastened to a loop or bend in the middle of the wire, which is drawn through double after the thread and detached. Then the pin is passed through the same punctures, between the skin and the vein, *i. e.*, on the opposite side of the vessel to the double wire. This can easily be accomplished by pinching up the skin between the finger and thumb, and slipping the vein out from between them by a slight rolling motion. The wire loop is then slipped over the end of the pin, and the latter cut off a short distance from the puncture. The ends of the wire are then crossed under the shaft of the



pin, twisted round the bent part, fastened through the loop, and cut off. Then by twisting the pin upon its own axis, the wire is gradually tightened upon the vein, and can be made to grip tighter as the latter ulcerates through, by giving a turn to the pin. When it is desirable to withdraw the pin and wire, it can be done with very little pain by untwisting the ends of the wire from the pin and drawing out the latter in the usual way. This sets free the wire, which can then be also easily withdrawn without the delay of waiting (if not desirable) until the whole of the enclosed tissues are completely ulcerated through. Two punctures only are left, which heal up rapidly after the wire is withdrawn. Usually no suppuration follows. No irritating pressure is made upon the punctures, as in the apparatus used sometimes for tightening the threads. By the use of metal instead of thread, there is less chance of retention of putrid or purulent matter in contact with the living and absorbing tissues, and of pyæmia, while complete division of the vein by a *double acupressure* is effected.

Both before and after any of these operations, care must be taken to avoid every cause of inflammation; because any of them may be followed by abscess or pyæmia, if precaution be neglected.†

II. PHLEBOLITES are calcareous concretions, formed by the de-

* This diagram gives an imaginary view from behind the vein.

† Vide Arnott in Med. Chir. Trans., vol. xv.

ation of coagula, in dilated veins. The following figure repre-
ts a patient of Mr. Fergusson's, in whom several of these con-

ions formed in pouches of irregularly-dilated veins under the lower
. They were extirpated by the knife, which is the only remedy
liable.

CHAPTER IX.

INJURIES AND DISEASES OF THE NERVES.

OMPLETE DIVISION of a nerve produces palsy and loss of sensi-
r in the parts to which it is distributed. The nerve, however,
readily unite in the same manner as bone or tendon, and sensi-
and motion will return. Sensibility has been known to return
e case in three weeks (in a case related by Paget in ten days), and
ower of motion in four weeks, after division. A nerve may also
er its functions after a small piece of it has been removed. Some-
, however, the divided ends, instead of uniting, shrink and be-
bulbous, as they do in a stump after amputation.*

The bulbous ends of a nerve which had not united have been cut out, but
ut avail. Vide Sir G. Ballingall's Mil. Surg., p. 249.

II. Partial Division.—If a nerve is partly divided, leaving some fibres on the stretch, as sometimes happens in venesection, very disagreeable consequences may ensue, such as immediate severe pain, recurring in paroxysms, and shooting in the course of the nerves; violent spasms, or palsy of the limb; fits of epilepsy; and great disorder of the digestive organs. The same symptoms may also ensue if a nerve has been bruised, or compressed, or stretched; or if it it has been divided, and its extremity has become implicated and compressed in a cicatrix. This not unfrequently happens after amputation, and produces excruciating pain, with spasm and retraction of the muscles of the stump, causing it to become conical.

Treatment.—If these symptoms come on *immediately* after a wound, so that it is probable that a nerve has been partly divided, an incision may be made so as to divide it completely. If, however, they appeared whilst a wound was healing, the best plan is to remove the cicatrix entirely. But it unfortunately happens, that neuralgic pains, when once established, do not always cease, even when the cause which produced them at first is removed. Very disagreeable consequences, in the shape of palsy, or numbness, or spasm, are sometimes caused if a nerve is subjected to pressure, as, for instance, the pressure of crutches on the axillary nerves; or from a blow, such as people often meet with on the ulnar nerve above the elbow; or from a violent stretch. Leeches, blisters, and the application of mercurial ointment, or of opiate or belladonna plasters, or painting with tincture of aconite, are the chief remedies.

III. Rheumatic Inflammation.—In a recent case, thorough purgation by calomel, colchicum, rhubarb, and carbonate of potass, may cut short the attack. In chronic cases, the iodide of potassium, guaiacum, and other anti-rheumatic remedies, must be used according to circumstances. Lumbago and sciatica are thus treated.

IV. Neuroma signifies a fibrous tumour developed in the sheath of a nerve. According to Dr. Van der Byl and Dr. Snow Beck it originates in an exudation around the tubules of a single fasciculus, within the neurilemma. This becomes organized into a fibrous or fibroid tumour, which enlarges and obliterates the adjacent nervous tubules by its compression.* Such tumours are smoothly globular or oval, and may vary from the size of a pin's head to that of an orange. Often they exist in great numbers in the nerves of one patient; and are painless; whilst, as we notice in the Section on Tumours, p. 102, one single small fibrous or cartilaginous tumour, which has no visible connexion with any nerve, may be the seat of the most excruciating pain. Yet these tumours, like any other morbid condition that may exist in or about the trunks of nerves, may produce every conceivable symptom of nervous irritation. Iodine paint, externally, and iodide of potassium, internally, may be tried; but if they fail, as they most likely will, any tumour which is troublesome must be extirpated, pro-

* See R. W. Smith, of Dublin, on Neuroma; Dublin, 1849; Van der Byl, Pathological Trans., vol. vi.

vided that it be not intimately embedded in the substance of a large nerve, such as the sciatic, the division of which would paralyze a limb.

V. NEURALGIA, or TIC-DOLOREUX.—This affection may be *defined* to be severe pain affecting the nerves, not necessarily produced by organic lesion. It occurs in paroxysms of very severe pain, mostly of a plunging, lancinating character, shooting in the course of the nerves. It most frequently attacks persons of middle age, female sex, and comfortable circumstances.

Causes.—The exciting causes may be of two orders. 1. There are some which act upon the nerve that is the seat of pain. Thus neuralgia may be produced by wounds and other injuries, as before related; by tumours at the origin or in the course of the nerve, especially cancer; by spicula of bone pressing on the nerve (which is a frequent cause of facial neuralgia); or by some disease in the brain or spinal cord at its origin.

2. It may be caused by states of the blood; as, for instance, by loss of blood and debility, accompaneid by pallor and anæmia, especially if combined with torpor of the kidneys and bowels; by wet and cold; by irritation of the skin from eruptions or wounds; by carious teeth; by disorders of the alimentary canal; by a rheumatic taint; sometimes by diseases of the urinary or other internal organs; lastly, by *malaria*. When arising from malaria, it is generally *intermittent*, like other diseases arising from the same source, and occurs at regular intervals. But all intermittent neuralgia is not necessarily caused by malaria; because this, as well as other nervous affections, may occur only at stated periods, although caused by a local source of irritation that is permanent.

The *nature* of the complaint is apparently *functional* derangement. The suddenness of its accession and departure, and the absence of organic change in nerves that have been affected for years, prove that it is not essentially inflammatory. See p. 20.

The most common forms of neuralgia are—the *Supra-orbital Neuralgia, Brow Ague*, or *Hemicrania*, which is usually caused by malaria; neuralgia of the *superior* and *inferior maxillary* nerves, which is often caused by diseased teeth, or disease of the bony canals through which those nerves pass; and neuralgia of the breast and testicle, which will be treated of elsewhere: it may also attack the extremities, or any internal organ.

Treatment.—The *indications* are three. *First*, to remove all sources of irritation which may affect the painful nerve, either at its origin or in any part of its course; remembering always that the painful spot is very seldom the real seat of the disease; *secondly*, to amend any disorder of the constitution that can be detected; *thirdly*, to alleviate pain.

In the *first* place, therefore, the whole course of the affected nerve should be thoroughly examined; and if there is a cicatrix, or tumour, or wound, or a carious tooth, or an abscess, or ulcer, or hernia, or aneurism, to which the pain can be attributed, measures should be

taken for their removal if possible. In cases of neuralgia of the extremities, if there is any tenderness, or other reason for suspecting inflammation of the nerve or its sheath, leeches and blisters, followed by liniments (especially F. 145, 151), applied in the course of the nerve, combined with proper constitutional remedies, may effect a cure. The head, and particularly the spine, should be well scrutinized. If there is any vertebra particularly tender, an opiate or belladonna plaster, or a plaster of ammoniacum with mercury, or, in extreme cases, the tartar-emetic ointment may be applied. This is the condition which has been described under the term *Spinal Irritation*. But the writer is more inclined to believe that this is an effect of a general nervous or hysteric condition, than an original or substantive disease in itself. The condition of the great secreting organs, as well as of the stomach, uterus, and rectum, should also be ascertained, in order to make sure that a morbid condition of one of these parts is not the real source of the evil.

Secondly, The state of the constitution must be regulated in the same manner as was directed in the treatment of chronic inflammation. If there are paleness of the lips, emaciation, and debility, iron, bark, and other tonics may be given with advantage. Inquiry should always be made in these cases for piles, menorrhagia, Bright's disease of the kidney, and other weakening ailments. On the other hand, purging and low diet have cured cases attended with hard full pulse and plethora. In all cases, the appetite, the tongue, the biliary and alvine secretions, and the state of the uterine system, should be investigated. In the brow ague and other cases arising from malaria, quinine should be given in doses of three grains every four hours, F. 3; if it fails, arsenic, F. 97; or the extract of nux vomica, in doses of gr. $\frac{1}{4}$ *ter die*, or guaiacum, may de tried. In cases of a rheumatic or gouty character, colchicum, F.70, &c., may be of service. Asssafœtida with aloetic purgatives and valerian may be given if there are hysterical symptoms, and sarsaparilla with iodide of potassium, F. 197, might be tried; or the hydrochlorate of ammonia, or the nitrate, if the malady has followed syphilis, or if there is any reason to suspect thickening of the bones of the skull. But all lowering remedies, and especially mercury, should be used with the utmost care and hesitation.

Thirdly, If no cause whatever can be detected; or if, when detected, it cannot be removed; or if, as frequently happens, even though removed, its removal fail to cure the disease, an *empirical* and *palliative* plan of treatment is the only resource. A course of *purgatives*, especially the croton oil, in doses of ♏ $\frac{1}{2}$ *ter die*; *tonics*, especially the quinine, carbonate of iron, and oxide or sulphate or valerianate of zinc; any remedies, in fact, that have been known to do good, may be tried in succession; taking care, however, not to impair the constitution by giving them at random. Opium, morphia, hyoscyamus, belladonna, conium, stramonium, or prussic acid, given internally; friction with ointments, or alcoholic solutions of veratria, or aconite (ʒss ad ʒi), chlorodyne, subcutaneous injection of morphia—galvanism, acupuncture, the moxa,

the actual cautery, and the outward application of chloroform, generally afford some relief, and sometimes completely cure. *Division of the nerves*, with or without *excision* of a portion, is the last and a very bad resource. It may produce instant ease: this, however, lasts but a short time; and the oftener it is repeated the more transient are its effects. Sometimes, after repeated divisions, the pain is as severe as ever, although the part may become quite numb and insensible to the touch. The infra-orbital and mental nerves (which may be divided from within the mouth just as they escape from their foramina), the frontal, the radial, just after it has passed between the supinator tendon and the bone, and the digital, are those which have been most frequently operated upon.

VI. ANOMALOUS NERVOUS AFFECTIONS.—The same local and constitutional causes that gave rise to neuralgia, may also occasion every other symptom that can be produced by functional nervous disorder; such as rigid and permanent spasm (as in wry neck), or twitching and convulsion of muscles; difficulty of swallowing and performing evacuations, owing to spasms of the œsophagus, of the sphincter ani, or of the perineal muscles; sneezing, dumbness, stammering, thirst, and affections of the sight and hearing. The treatment must be conducted on the same principles.

CHAPTER X.

INJURIES OF THE HEAD.

SECTION 1.—WOUNDS OF THE SCALP.

WOUNDS and contusions of the scalp, be they ever so slight, are not to be neglected. For they may be followed by erysipelas, or by inflammation and suppuration under the occipito-frontalis, or within the cranium, or by suppuration of the veins of the diploe, and general pyæmia, that may easily prove fatal. Wounds should be accurately and quickly closed; but first of all, care should be taken to wash away all foreign bodies and clots with *clean* water, and a bit of clean old linen, or a clean sponge. The writer will say, once for all, that sponges that have been used to wipe up foul discharges should *never* be used for recent wounds, particularly of the scalp. No part of the scalp, however torn or bruised, should be cut away. Cases are known in which almost the whole scalp has been stripped from the bone, and yet has been laid in its place, and the patient has perfectly recovered. It is wise not to use stitches if it can be avoided. Neither are they usually necessary; for the wounds may be controlled by plasters and bandages. If used, they need not go through the whole thickness of the scalp. It is a good plan to seal

up the wound with *collodion*, or *Friar's Balsam* on lint; so as to coagulate the blood outwardly, and lessen the risk of suppuration. The patient should be confined to the bed, or to the house, and be purged, and put upon regular but not low diet.

Hæmorrhage from small vessels is usually controlled by closing the wound and using pressure. If a large vessel be wounded, it should be tied. Sometimes a blow on the head, which has not pierced the skin, causes an extensive and increasing extravasation of blood under the scalp, rendering it evident that an artery has been divided by the blow. The exact situation of the injured vessel should, if possible, be ascertained, and pressure be applied there with a small pad of lint and a well-applied compressing bandage.

If *suppuration* occur, which will be indicated by rigours, chills, and dry tongue, with increase of swelling, attended by a throbbing pain, and if purgation does not remove these symptoms, adhesions may be separated at any suspicious spot; or a moderate incision down to the bone be made at any part where mischief is likely to occur. Incisions are the *sine quâ non* in suppuration under the scalp. This is usually indicated by a puffy swelling around the eyes and about the temples, with severe pain of a throbbing character in the head.

If there is mere *serous effusion* in this situation, it may, if necessary, be let out by one or more punctures with a lancet. If blood is extravasated without a wound, absorption is to be promoted by moderate purgation and cold lotions; and no incision is to be made, unless positively necessary, on account of the tendency to suppuration and putrefaction which the admission of air promotes.

SECTION II.—CONCUSSION OR CONTUSION OF THE BRAIN.

Definition.—Concussion (commonly called stunning) signifies sudden interruption of the functions of the brain, caused by a blow, or other mechanical injury to the head.

Symptoms.—There are two degrees of it. 1. In ordinary cases, the patient lies for a time motionless, unconscious, and partially insensible; if roused and questioned, he answers hastily, and again relapses into apparent insensibility; after a time he moves his limbs as if in an uneasy sleep, and vomits, and frequently recovers his senses instantly afterwards; remaining, however, giddy, confused, and sleepy for some hours. 2. In the more severe degree the patient is profoundly insensible, the surface and extremities pale and cold, the features ghastly, the pupils sluggish and sometimes dilated, but equal on both sides, unless the brain is injured: in less severe cases they may be contracted, the patient turning away irritably from the light; the pulse feeble and intermittent, or perhaps insensible, and the breathing slow, or performed only by a feeble sigh drawn at intervals.

Vomiting is an important symptom. It is not present in very slight cases, nor in very severe ones; and its occurrence is mostly an indication of approaching reaction and recovery.

Consequences—1. In cases not attended with severe lesion, the patient suffers from some degree of headache and feverishness for a few days, which may be easily aggravated into a fatal inflammation of the brain. 2. If the concussion be very severe, it may be followed by death; and there is no doubt but that it is attended with more or less of contusion, ecchymosis, rupture, and extravasation of blood in small specks, or in larger masses; and that in the cases formerly described, in which persons were said to have died of concussion purely, without anatomical lesion, there was some injury of the spine or disease of the heart to account for death. And the word concussion really means contusion.* The degree of danger in any case may be estimated by the degree in which the spinal and ganglionic systems appear to be implicated. If, therefore, the pulse and respiration continue feeble for many hours; if the eyelids do not move when irritated, and the legs are not drawn up when the soles of the feet are tickled, the prognosis will be serious. 3. Concussion is occasionally succeeded by a peculiar state of insensibility, which may last some days. The patient lies as if in a tranquil sleep; his pulse is regular; but on the slightest exertion it rises to 130 or 140, and the carotids beat vehemently; when roused he answers questions, but immediately relapses into unconsciousness. Some patients in this state resemble somnambulists; they may get out of bed, bolt the door, shave, or make water, but still are insensible to what passes around. 4. It may leave a very infirm state of the health and intellect; impairment of the memory, or of the senses, especially of smell and hearing; and a constant tendency to inflammation, and to extravagant actions after drink or any other excitement.

Pathology.—The early symptoms, it will be seen, are partly those of impaired cerebral function, partly those of collapse, or syncope. Vide p. 1. It is commonly said that concussion may prove fatal without any injury that can be discovered by dissection; but Dr. Bright pointed out, many years ago, that the brain may be studded with minute ecchymoses, the size of pins' heads. The difference of injuries, however, inflicted slowly and gently, from those inflicted suddenly and with violence, is remarkable. As Mayo long ago observed, great part of the brain of an animal may be gently and quietly sliced away with little or no effect; but if ever so small a portion be suddenly crushed, the heart stops directly.†

* See Mr. Prescott Hewett's Lectures, Med. Times and Gaz., 1858.

† "The English dragoon sword is so blunt that the strongest man cannot drive it through the head-dress of the Sikh or Afghan; nevertheless the enemy is most often beaten from his horse, and frequently killed by the violence of the shock. Not so, however, with the trenchant blade of the Sikh: this weapon, wielded by a strong man, will cut through any head-piece, and bury itself perhaps in the brain; and yet you find no symptoms of concussion or compression. In the former example the soldier is effectually disabled, often killed outright; in the latter, although the individual is mortally wounded, he may be able to continue the fight, and even to kill his antagonist, before he falls himself dead or dying from his horse."—Cole's Field Practice in India, p. 45. See also a very able paper in the B. and F. Quarterly, Jan. 1853, by Dr. E. C. Williams.

Treatment.—The *indications* are: 1, to recover the patient from insensibility and collapse; 2, to prevent inflammation of the brain; 3, to restore any faculties that may remain impaired.

1. In order to fulfil the first indication, friction of the surface of the hand, and the application of warmth to the feet, or mustard plasters to the calves of the legs, may be resorted to, if the depression is very great, and the pulse very low; but it is better in most cases to leave the patient to recover by himself, with the head on a level with the chest, than to be officious in administering stimulants, which would increase the effusion of blood, supposing the brain to be lacerated. Mr. Guthrie's sentiments on this point are very decisive. "It is useless to open the patient's veins," he observes, "for they will not bleed until he begins to recover, and then the loss of blood will probably kill him. It is as improper to put strong drinks into the mouth, for he cannot swallow; and if he should be so far recovered as to make the attempt, they might probably enter the larynx and destroy him. If he be made to inhale strong stimulating salts, they will probably give rise to inflammation of the inside of his nose and throat, to his subsequent great distress."*

Professor Miller has well observed, that during the insensibility from shocks the patient should be examined to ascertain what other injuries, if any, he has sustained. Broken bones, dislocations, and wounds should then be set to rights.

2. After reaction has taken place, the bowels should be freely acted on, and perfect rest and low diet should be observed. If the pulse becomes hard and frequent, and if the patient complains of pain, throbbing or tightness in the head, or becomes flushed, or delirious, or stupid and comatose, if vomiting come on again, or heat of head and dryness of tongue, all which symptoms indicate the approach of phrenitis, blood should be taken from the arm, or by leeches or cupping from the head, the purgatives should be repeated as often as may be necessary, with saline and antimonial draughts in the intervals. If the head should be shaved and kept wet with evaporating lotion, iced water, or ice-bag. As a general rule, after any severe injury on the head, the patient should observe a cautious antiphlogistic regimen for a month or six weeks—carefully keeping himself free from fatigue, intemperance, and excitement. If violent delirium or convulsions come on after an injury to the head which has been followed by copious venæsection, and if they are not relieved by further depletion, or if that seems inexpedient, they would probably yield to acetate of morphia.

3. In order to remove headache, deafness, giddiness, squinting, loss of memory, tinnitus aurium, and other remote consequences of concussion, a course of mild alterative mercurials, repeated blistering, issue or seton, the shower-bath, change of air, and a most regular life are the remedies.

* Guthrie, G. J., on Injuries of the Head affecting the Brain, Lond. p. 11.

SECTION III.—COMPRESSION FROM EXTRAVASATED BLOOD.

Symptoms.—The symptoms of compression of the brain are those of apoplexy. They are, insensibility; palsy (sometimes general, sometimes confined to one side); dilated and insensible pupil; slow, labouring pulse; skin often hot and perspiring; retention of the urine, through palsy of the bladder; involuntary discharge of fæces, through palsy of the *sphincter ani;* stertorous breathing, owing to palsy of the velum *pendulum palati;* and *whiffing* or *puffing* respiration, from palsy of the buccinator and other facial muscles. Sometimes, however, the pupils are contracted, and sometimes one is contracted and the other dilated, usually indicating the side of the brain implicated most. Sometimes more or less squinting is present, or the eyes are turned spasmodically upward, so that only the whites are seen.

That side of the body is paralysed which is opposite to the injury; and the paralysis, like the insensibility, may vary immensely in degree. There may be every degree from mere numbness and weakness to complete loss of power; and every degree of interruption to the mental functions, from slight drowsiness, or slowness, to utter unconsciousness. Convulsions and muscular twitchings or rigidity indicate generally irritation or laceration of the brain or its membranes.

Causes.—Compression (surgically considered) may be produced by three causes. 1. By extravasation of blood. 2. By fracture of the skull, with depression. 3. By suppuration within its cavity.

The *symptoms of compression from extravasated blood* generally show themselves in the following manner:—The patient receives a blow, and becomes stunned and insensible from the concussion, with extremely feeble pulse and cold skin. After a while he recovers his senses; but again in an hour or two he becomes sleepy, confused, and insensible; with slow stertorous breathing, slow pulse, and dilated pupils. The symptoms closely correspond with those of one form of apoplexy, called the *ingravescent;* in which the patient suddenly feels an acute pain in the head, caused by the bursting of a blood-vessel, and becomes sick and faint—in fact, suffers from concussion. Then he recovers his senses; but shortly afterwards, as the extravasation from the ruptured vessel increases, becomes quite comatose.*

On the other hand, if a large quantity of blood is extravasated rapidly, the symptoms of compression may immediately succeed the insensibility of concussion, without any interval of consciousness.

The blood may be situated, 1, between the dura-mater and skull; and if in large quantity, it proceeds most likely from laceration of a branch of the middle meningeal artery. It may, however, proceed from one of the sinuses, particularly the lateral. It is the common consequence of fracture, by which the vessels running in the grooves of the bone are torn through. 2, between the membranes. Here we may refer to p. 23, for a notice of the fact, first clearly pointed out by

* Copland, Dict., *Art.* Apoplexy.

Mr. Prescott Hewett, that injuries are often accompanied with extravasation within the cavity of the arachnoid; and that the blood may coagulate, forming a thin layer, which adheres and becomes vascular like a false membrane. It, in the substance of the brain.

The diagnosis between the symptoms of concussion and those of compression is a sort of *pons asinorum* and bugbear to young students, who are often led to expect sharply-drawn distinctions which are seldom found in practice. Moreover, it is often confused by ideas that the injury in concussion is *structural*; whereas, as we have taken it, the real condition of a concussed brain is one of contusion and asthyxiosis, which may produce symptoms of their own. The leading points of distinction are obvious enough.

1st. The symptoms of concussion always follow the accident immediately; those of compression from effusion of blood may come on after an interval. "The first stunning or deprivation of sense," says Pott, "may be from either: no man can tell from which; but when the first symptoms have been removed, or have spontaneously disappeared, if such patient is again oppressed with drowsiness or stupidity, it then becomes most probable that the first complaints were from concussion, and that the latter are from extravasation." 2ndly. In concussion the pulse is feeble, the skin pale and the respiration sighing and feeble; but the greater the insensibility the weaker will the pulse be. In compression, of the contrary, when reaction is thoroughly established, the pulse will be slow and full, and the skin hot and perspiring. 3rdly. In concussion breathing and involuntary power are rapid in mere concussion, recovering in proportion. 4thly. The pupil in concussion is variable: sometimes contracted, sometimes dilated, and not always insensible to light: in compression, it is almost always dilated and insensible, and sometimes unequal on the two sides.

Treatment.—The head should be shaved and examined, and if there be any sign of fracture or depression, the case must be treated as one of compression. The endeavours being to avert inflammation, and prevent absorption of the blood, by cold applications to the head, calomel, and occasional or repeated doses. If, in spite of the above measures, the insensibility continues, and the lungs become clogged with mucus, and the breath escapes from the corner of the mouth with a peculiar whiff during expiration like that of a stertor, showing paralysis of the buccal cheek and pressure upon the nasal-cephalon, which are very perilous symptoms, the last resource — and under these circumstances I would be considered a very desperate one, and one which modern surgeons because they think they have nothing to resort to,—is trephining. The trephine should be rather large, because the blood is almost always found coagulated. Perhaps the middle table may be found extravasated, while only a thin layer of the outer table. An opening in the inner table must be made at the seat of injury; or, if that is unknown, over the parietal bone on the side opposite to the paralysis, and over the course of that branch of the middle meningeal artery which will be supposed to furnish the haemorrhage.

en a piece of bone has been removed, the dura-mater, in its
l state is found to be level, and of a reddish-silvery colour, and it
nd falls synchronously with the motions of respiration; but if
is fluid underneath, it bulges up tightly into the aperture made
trephine, it is of a darker purplish colour, and its motions are
distinct or entirely lost. In this latter case a puncture should
de to let the fluid escape; and numerous instances are on record
ich, after the surgeon has punctured the distended dura-mater,
me ounces of blood have escaped, the patient has recovered his
ousness immediately.* If on opening the dura-mater the blood
be found under the pia mater, and, perhaps, in the substance of
ain, the areolar membrane holding it should be carefully *torn* by
rceps, to permit the coagula and disorganized brain tissue to

ly, to quote from the valuable practical remarks of Mr. P.
t, supposing a man to fall—from a ladder, for instance—in a fit
pleasy, care must be taken not to ascribe to the fall the effects of
sense which preceded it.

SECTION IV.—FRACTURE OF THE SKULL.

ACTURES of the skull are caused by great violence, such as blows
s on the head, and gun-shot wounds. If the blow be caused by a
blunt object, or by a
n the head, it will most
result in a widely ex-
l fissure, running perhaps
the vault or base of the
and tearing arteries,
s, or nerves in its way;
re of the base, for ex-
, is common when the
t falls on his head from
ght, so that the weight
whole body tells upon
se of the skull through
nal column.

he blow be caused by a
instrument, as a ham-
r pickaxe, or brickbat, it
robably cause a *starred*
ion confined to the seat of injury. Sometimes the outer table
hew a small hole, while the inner table will be starred and de-
l in picula much more extensively, occasionally tearing the dura-
and injuring the brain.

SYMPTOMS and consequences of fracture of the skull depend on
nditions which accompany it; especially, 1. On the amount of

* Guthrie, op. cit., pp. 39, 125; Brodie, Med. Chir. Trans., vol. xiv.

concussion. 2. On the forcing in of portions of bone so as to compress the brain, or on internal hæmorrhage. 3. On the complication with scalp wound. 4. On the situation. 5. On the inflammation excited subsequently.

1. SIMPLE FRACTURE WITH DEPRESSION may be ascertained by a careful examination of the shaved scalp, when, if it exist, there will be felt a depression at one part, with a corresponding edge or projecting ridge near it. Sometimes a coagulum of blood or other effusion under the scalp conveys the feeling of a sharp elevated ridge of bone: it may be known, however, by its yielding to firm pressure with the finger, and by observing that no part of the bone is *below* its natural level, at the same time that the edge of the apparent depression is raised in a rim above the level of the surrounding skull. Sometimes, too, an irregular conformation of the sutures and Wormian bones may be mistaken for fracture.

Moreover, a mere driving in of the outer wall of the *frontal* sinuses or mastoid cells, or any place where the diploe is large, is not necessarily attended with injury to the brain. Occasionally both tables may be driven in upon one of the large venous sinuses, or between the cerebral hemispheres without compressing the brain substances.

Treatment.—1. In a case of *simple* depressed fracture, if there are no symptoms of compression, and if the patient is conscious and rational, he should be bled, purged, and kept under the strictest antiphlogistic regimen; and then, perhaps, recovery may be completed without the slightest appearance of compression, and inflammation be averted. Even if there be *slight* symptoms of compression, the same plan is to be adopted.

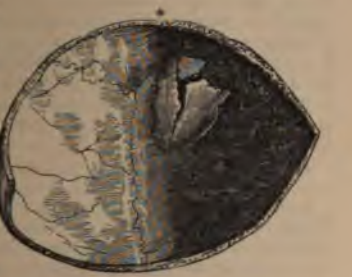
In children, whose bones are soft and thin, great indentations and depressions may be produced without fracture. They are to be treated antiphlogistically; and if the bowels are kept well open, they may not cause any bad symptom whatever, and the bone may rise in time to its proper level.

2. If the fracture be *compound*, in like manner, as a general rule, it is better not to trephine, unless there are symptoms. If *commixed*, and if splinters are sticking into the brain or its membranes, the bone must be elevated. If possible, it should be done with the elevator alone. But if one piece of bone is wedged in under another, a *small* aperture should be made with the trephine, or Hey's saw, in order to make room for employing the elevator. If any pieces of bone are perfectly loose and detached, they must be removed; but not if they have a pretty good adhesion to the pericranium or dura-mater.

3. FRACTURE OF THE INNER TABLE.*—This part may be splintered extensively by some injuries which do no great damage to the

* Mr. W. F. Teevan, of the Westminster Hospital, has made numerous experiments which show that the aperture of entry is caused by the penetrating body only; and that the aperture of exit is larger, inasmuch as it is made by the penetrating substance plus the fragments of bone driven out of the external table and diploe.—Experimental Inquiries on Wounds of the Skull. Brit. and For. Med. Chir. Rev., July 1864.

table; especially by sabre-cuts descending perpendicularly; t-shots, and blows with pokers and similar weapons. When is reason to suspect this, a most careful examination should be with the probe, and, if discovered, the trephine should be em- to raise or remove any splinters that may compress or irritate rface of the brain.



FRACTURE OF THE OF THE SKULL may various directions, but frequently through the n, squamous, basi-sphe- and ali-sphenoid bones. agnosis will be founded On the nature of the in- for the patient has pro- pitched on his head as a wound or bruise e vertex, but no frac- there. 2. There will probably be copious n bleeding from one the blood coming from the diploe of the bone, or from the al or lateral sinuses, being permitted to well out through the anum by laceration of the membrana tympani. In this case, if outh and nostrils be closed, air will perhaps also bubble out gh the external auditory meatus in expiration. 3. After bleeding ased, a most significant symptom is the draining away through ar of the cerebro-spinal fluid from beneath the arachnoid. It is a fluid, hardly coagulable by heat, and containing much less ein and saline matter than serum does. This indicates that the ire passes through the internal auditory meatus, and has ruptured ube of arachnoid, which accompanies the auditory and facial into that meatus, and so allows the escape of the cerebro-spinal Immense quantities of it may be discharged. In one case ed by Hewett, the serous fluid seemed to come from the internal mastoid cells or tympanum, there being no fissure found (though ully looked for) on the inner surface of the skull. 4. Various toms may be noticed, indicating damage to the nerves that escape e base of the skull. Thus extreme deafness points to the auditory; sis of the muscles of the face, inability to close the eye tightly, dragging of the mouth to the opposite side, point to the facial ; loss of sensibility in either half of the tongue, to the third n of the fifth; loss of motion, to the ninth; inability of swallow- nd slow or stertorous breathing, to the eighth; and thus the cation of these nerves shows the course of the fracture to be gh their several foramina. 5. Bleeding from the nose or mouth, reat ecchymosis within the orbit, not a mere speck of blood

* Fracture of the Inner Table of the Skull, St. Mary's Museum.

beneath the conjunctiva, but a complete ecchymosis coming from behind, will also show the direction of fracture, across the sphenoid, ethmoid, and frontal bones. In some cases traumatic aneurysm of the orbit has followed, and has been relieved by ligature of the common carotid.

In this and in other fractures of the skull the symptoms depend on the amount of injury to the brain, and so does the *prognosis*. Stupor, dilated and unequal pupils, with rapid pulse, hot skin, dry tongue, and delirium, are unfavourable symptoms; yet fracture of the base has been shown not to be necessarily fatal as was once supposed; and if there is no primary injury to the brain, if the patient is thoroughly purged and kept on low diet and in the most absolute repose, so as to arrest inflammation, he may recover.*

SECTION V.—WOUNDS OF THE BRAIN, AND HERNIA CEREBRI.

I. WOUNDS OF THE DURA-MATER add very considerably to the danger of compound fractures of the skull, both from the risk that inflammation may spread over the surface of the arachnoid, and from the greater chance of hernia cerebri. Hence this membrane should never be punctured in search of fluid, without due consideration.

II. WOUNDS OF THE SINUSES are of no great consequence, provided the blood does not accumulate within the skull; hæmorrhage from them is easily restained by pressure.

III. WOUNDS OF THE BRAIN, whether incised or lacerated, are not attended with special and recognisable symptoms besides those which arise from the concussion, compression, or inflammation that may accidentally be present. Instances are numerous in which portions of the brain have been lost, without any ill consequences at the time or afterwards. But yet Sir B. Brodie has observed in some cases a greater degree of mental confusion than usually attends concussion, and, in others, spasmodic twitchings of the muscles.

If *foreign bodies* are embedded in the brain, the danger will be materially augmented. Sir B. Brodie says, that no foreign body, whether a portion of the skull or not, is to be removed, if the removal will add in the least to the irritation or injury; but the practice of most surgeons is to remove them without delay, but with as little disturbance as possible.

The *treatment* of these cases consists in the preventing of inflammation, and in causing the wound to cicatrize without the formation of *hernia cerebri*.

IV. HERNIA CEREBRI.—When a portion of the skull has been removed, the brain is liable to protrude through the aperture in the form of a rounded tumour, styled *hernia* or *fungus cerebri*. Mr.

* See Guthrie, op. cit.; Sharp on Injuries of the Head, Lond. 1851; MM. Laugier, Robert, and Chassaignac, in Ranking's Abstract, vols. ii. and iii.; Mr. Hilton's excellent Clinical Lectures, Lancet, 1853, vol. i.; and Prescott Hewett's Lectures, Med. Times, 1855 and 1858.

Guthrie describes two varieties of it. In the first, which occurs within two days, the tumour is composed of coagulated blood, and is caused by hæmorrhage into the brain near its surface. It is accompanied with delirium and phrenitis, and is generally fatal. The best treatment is, to shave it off level with the surface, so as to permit a free discharge of blood. The other kind of tumour consists of brain itself, infiltrated with lymph and blood. If the dura-mater is still entire, the tumour causes it to slough by its constant pressure, and then protrudes through the aperture in the skull. As it increases in size, it suffers constriction from the aperture through which it passes, and sloughs; but is speedily succeeded by a fresh growth of brain and of fungous granulation, which undergoes the same processes, till the patient dies of the irritation.

Treatment.—In order to prevent this tumour, a well-regulated pressure, just sufficient to afford a natural support, should be made upon the brain by means of compresses of soft lint oiled, in all cases when the skull is perforated. If the fungus has already protruded, the best application is liq. calcis, with which the lint may be wetted. If this fail, and the degree of pressure requisite to prevent increase cause symptoms of cerebral oppression, the part should be shaved off level with the scalp, and any further growth be prevented by the liq. calcis and lint, and pressure, as before. Fungous granulations proceeding from the exposed pia- or dura-mater must be carefully distinguished from true hernia cerebri. These are best treated by the application of lunar caustic frequently.

SECTION VI.—TRAUMATIC INFLAMMATION OF THE BRAIN.

General Description.—Inflammation of the brain and its membranes rarely makes its appearance till a week after an injury, frequently not till three weeks, or even later. Its symptoms and progress are very various; sometimes sudden, violent, and soon terminating in destructive suppuration; sometimes slow, insidious, and unsuspected, till suddenly manifested by fatal coma or palsy.

Symptoms.—*First stage.*—The patient complains of tightness and pain in the head, aggravated by heat, motion, and anything that causes excitement of mind or body, together with a disagreeable sense of languor or weakness, confusion of ideas, quick pulse, disturbed sleep, nausea, and want of appetite, and alternate flushing and paleness. *Second stage.*—The symptoms having lasted a day or two, there comes on a violent rigour, followed by burning heat of the skin: the pulse is hard and frequent; the carotid and temporal arteries pulsate vehemently; the headache becomes most intolerable and throbbing; the pupils are contracted; light is unsupportable to the eyes, and sound to the ears; the tongue is dry, the bowels obstinately costive, and the stomach rejects everything with frequent retching. Besides these symptoms, violent delirium or convulsions come on at intervals, or perhaps coma. If they are unrelieved, the *third stage* soon follows.

The pulse loses its force, and becomes either slow and oppressed, or excessively rapid; and squinting, low delirium, convulsions, or palsy, soon usher in death. Rigours, followed by squinting, dilated pupil, stertorous breathing, coma, and palsy, are indications of suppuration.

Certain changes on the outside of the head also accompany the mischief that is going on within. Supposing the injury which is the cause of the inflammation to have been accompanied with a wound, which up to the occurrence of the inflammation has been going on well,—to use the words of Pott, "the sore loses its florid complexion and granulated surface, and becomes pale, flabby, glassy, and painful; instead of good matter, a thin gleet is discharged from it; the lint with which it is dressed sticks to all parts of it; and the pericranium, instead of adhering firmly to the bone, separates all round from it to some distance from its edges." The bone, moreover, may become white, dry, and bloodless. If there be no wound, the scalp will present a puffy, circumscribed, indolent tumour at the seat of injury, on incising which the pericranium is found detached, and the tissues infiltrated with serum. If the dura-mater is exposed, it at first appears of "a dull, sloughy cast, and smeared over with something glutinous," and subsequently is covered with matter.

Pathology.—So far we have described the classical or heroic form of acute encephalitis. But many cases will be met with in which the order of symptoms is very irregular. Thus, in the first place, severe and continuous vomiting may be the earliest symptom, without any complaint of the head; or a sudden attack of convulsions, or of furious delirium; or a sudden palsy, owing probably to insidious mischief which betrays itself when too late; or pains in the head of an intermitting character; or severe shiverings, terminating in a hot and sweating fit;—and many of these symptoms may occur without any fixed or regular signs of inflammation being betrayed by the pulse. Again, injuries of the skull are liable to be followed by *pyæmia*, with abscess in the lungs, liver, or joints, and the other signs of that affection. This may occur from mere bruises which have injured the diploe, without fracture of either table, and without wound. Sleeplessness, wild intermitting delirium, and sudden suppression of a flux of cerebro-spinal fluid from the ear, after fracture of the base of the skull, especially if accompanied by hot skin, quick pulse, and rigours, are very suspicious symptoms.

Morbid Anatomy.—The morbid appearances usually found are suppuration in the diploe; clots in the sinuses; exudation of yellowish or greenish lymph on the free surfaces of the dura-mater and arachnoid, covering perhaps extensive tracts, and perhaps partially or entirely converted into pus; similar exudation beneath the arachnoid, passing into the sulci, and thus appearing, on section, to be in the substance of the brain itself; serous effusion into the ventricles; softening, or abscess of the central part of the brain or cerebellum.

Prognosis will be unfavourable if the malady is not promptly relieved by depletion, or if it has advanced to its second stage.

TREATMENT.—The prevention of inflammation after injury depends chiefly on the most perfect quiet of mind and body, which may be insured by a careful administration of morphia; by free purging; a moderately low diet; and the application of cold to the head. The earliest symptoms are to be combated by free bleeding and leeching, with cold to the shaved head, and purgatives with antimony. If exudation seems to be pouring out, as indicated by the persistence of the symptoms, in spite of depletion, the remedies are mercury given so as to affect the system—for instance, two grains of calomel every six hours; blisters to the head or nape of the neck; mustard cataplasms to the feet; terebinthinate or stimulant enemata; and trephining, if suppuration is indicated by symptoms of compression (and especially by palsy of the opposite side of the body), by the above-mentioned state of the wound, or Pott's *puffy tumour*. The trephine should be large, and if the matter be seated between the dura-mater and skull, it may afford relief. But so capricious are the symptoms of injury and disease of the brain, so difficult the diagnosis, so impossible is it to be always sure of the precise seat of mischief, and so inherently dangerous are these injuries necessarily, that the trephine may not lay bare the real mischief, or even, if it does, may give no relief.

Abscess in the brain, or *softening*, may be very remote consequences of injury, not occurring perhaps for years. Their *symptoms* are very obscure and insidious. Occasional headache; general loss of health and strength; impairment of the memory or other mental faculties; quick pulse, and furred tongue; disorder of the eyes or ears; sense of constriction, or of coldness in the scalp, or of creeping in the limbs, with numbness, are the most frequent. But these are succeeded by sudden convulsions, or palsy, or coma, from which the patient soon dies, although he may perhaps recover for a time.

Treatment.—Blisters, issues, or setons; purgatives; the most regular diet, and avoidance of every kind of excitement of mind or body, are the remedies in case mischief is expected. After the occurrence of palsy, or other decided symptoms, blisters: leeches, if the pulse is strong enough, and there is pain or heat in the head; purgatives and enemata. But if the patient is low and feeble, he must be supported by mild nutriment and stimulants, especially ammonia, quinine, and nutritious soup.

SECTION VII.—TREPHINING AND PARACENTESIS.

I. TREPHINING.—The apparatus requisite for this operation comprises a large and small trephine, a straight and curved Hey's saw, an elevator, a couple of small pairs of holding forceps, with fine points, straight and curved—besides a good scalpel, and the other instruments which every surgeon is supposed to have in his pocket.

There are four cases which may require this operation. 1. Fracture of the skull with depression of bone. 2. Extravasation of blood under the skull. 3. Suppuration of the dura-mater. And, lastly, occasional cases of epilepsy arising from the irritation of a diseased spot

of the skull. For the first and last cases, the trephine should be quite small, so as not to sacrifice more than is absolutely necessary.

Supposing it to be a case of depressed fracture. In the first place, the bone, if not already laid bare by a scalp wound, must be exposed by an incision in the shape of a V, or H, or T. Then, perhaps, some loose fragment may be picked out, or a projecting point may be cut off with a Hey's saw, or with bone forceps, that will enable the surgeon to raise the depressed portion. But if this cannot be done, a circular piece, consisting of the edge of the depressed bone, and of the adjoining bone under which it has been wedged, must be removed. The pericranium being shaved off from the part which is to be perforated, the surgeon applies the trephine with the point of his forefinger protecting the crown, and works it with an alternate pronation and supination of the wrist, and when it has made a circular groove deep enough to work in steadily, he takes care to withdraw the centre pin. He saws on steadily and cautiously, pausing frequently and examining the groove with a probe, to ascertain whether it has reached the dura mater, and when it has, he introduces the elevator to raise the circular piece of bone. He must be particularly careful to fix the centre pin and the greater part of the circumference of the instrument, on firm bone,—and by no means to press heavily, whilst sawing, on any piece that is loose or yielding. The saw will be known to have reached the diploe by the escape of blood with the bone-dust; but it must be recollected that the diploe exists neither in children nor in the aged. When the piece of bone is removed, the surgeon must gently insinuate the point of the elevator under that which is driven in, and using his finger or the edge of the firm bone as a fulcrum, must carefully raise it to its proper level. Small detached portions driven under the rest must be removed carefully by the forceps. Then all loose fragments having been removed, and the wound sponged clean, the scalp must be carefully laid down, and the patient be put to bed. The trephine should not be applied in the course of the sutures or venous sinuses, nor over the lower part of the frontal or occipital bones, if it can be avoided; but, if necessary, there is no great objection.

II. PARACENTESIS CAPITIS, or puncture of the head, is an operation that has been resorted to by Dr. Conquest in hopeless cases of hydrocephalus in children. It consists in introducing a very fine trocar or grooved needle perpendicularly to the surface, through the anterior fontanel, as far as possible from the longitudinal sinus. When two or three ounces of fluid have escaped, the puncture should be carefully closed, and moderate support be applied to the head by bandages. If the child becomes faint, it must be kept in the recumbent posture, and have a few drops of sal volatile. The operation may be repeated at intervals of two or three weeks.*

* See Dr. Watson's Lectures in the Med. Gaz. for March 1841.

SECTION VIII.—TUMOURS.

I. TUMOURS OF THE SCALP are most frequently cutaneous cysts, or vascular tumours. (See pp. 108, 227.)

II. TUMOURS OF THE BONES are apt to be of most ivory-like density. If near the orbit, so as to interfere with the eye, or if very disfiguring, they may be removed.

III. TUMOURS WITHIN THE CRANIUM, that concern the surgeon, are usually fibro-plastic, or soft cancer, arising in the bone or membrane, and perforating the skull. Other enlargements, such as aneurysms, or hydatids, will produce similar symptoms at first. The earliest symptom is generally intense, long continued, and frequently returning headache. Then there may follow the signs of compression, in the form of gradually-increasing mental imbecility, and palsy of the limbs. Sometimes the patient is cut off with a sudden attack of hemiplegia. But if he survives long enough, the growth makes its way outwardly, perforates the skull, and appears as a soft lobular tumour. Attentive examination may perhaps detect two kinds of pulsation in it; one synchronous with the arterial pulse, the other with the rise and fall of the brain in respiration. The tumour cannot be moved laterally; but in its earlier stages may perhaps be returned into the skull, giving rise, when returned, to symptoms of compression of the brain which subside when it is permitted to protrude again.—See p. 377.

The *treatment* must be palliative; leechings, purgatives, and moderate diet. Any interference with the knife is almost sure to be fatal.*

CHAPTER XI.

DISEASES AND INJURIES OF THE SPINE.

SECTION I.—DISEASES AND DEFORMITIES.

1. LATERAL CURVATURE from debility of the bones, ligaments, and muscles, is exceedingly common in this country in young females from about the age of ten to sixteen. The first thing that attracts attention is a projection, or, as the vulgar say, *a growing out* of one scapula, or of one side of the bosom, or an elevation of one shoulder, most commonly the right. On examination, the spine is found to be curved like an italic *f*, and somewhat twisted on its long axis. The right shoulder and the right side of the chest are unnaturally high and rounded, whilst the opposite is depressed and concave. In the same way the left hip projects, whilst the loins on the right side are curved inwards.

Causes.—This affection is readily caused by occupations or postures that tax one side of the body more than the other; especially the habit

* See Lebert, sur les Mal. Cancéreuses, &c.

of *standing at ease* on the right leg, with the left knee a little bent; a common habit with all persons who stand long. By this means the left side of the pelvis is thrown up, and the right shoulder raised. Awkward one-sided postures in sitting whilst writing, or at needle-work, are also causes. We may add, that there are some circumstances which may possibly cause distortion, even in the healthiest adult; such as one leg being shorter than the other, or walking with a wooden leg. Why one-sided postures should cause distortion must be evident, when it is considered that the intervertebral substance is compressible, to such an extent, that an adult man of middle stature loses about an inch of his height after having been in the erect posture during the day, and does not regain it till after some hours of rest. "Since the united thickness of the intervertebral substance in an adult man is about 3·875 inches," we see that they lose nearly one-fourth by compression, which they do not recover till after some hours of rest. But if the weight of the body falls unequally on the spine day after day, it must be evident that they will become compressed on one side more than on the other; and that if their elasticity be impaired, and the muscles and ligaments be weak, and the bones soft, as they are in young persons who have not a sufficiency of fresh air, wholesome food, and active exercise, this lateral distortion will become permanent.*

Curvature from Rickets.—There is another form of curvature from debility, which chiefly affects young children of the lower orders, and arises from *rickets*. It is generally distinguished by the general rickety aspect of the patient (vide p. 239), and by the distortion of the limbs that is also present, as well as by the circumstance that the spine is not simply curved laterally, as described above, but is often curved directly forwards; the seat of this curvature being the upper part of the back; or perhaps it may be curved backwards.

Treatment.—The first and most essential measure is to strengthen the bones and muscles, by means of good diet, sea air, steel, cod-liver oil, or phosphate of lime, F. 201; the shower-bath; sluicing the back with cold salt and water in the morning; a hard mattress instead of a soft feather-bed; early rising.

* Bishop, Lancet, 1846, vol. i., p. 215.

† From a preparation of Mr. Fergusson's, in the King's College Museum.

and abstinence from books. 2. Whilst the back is weak, it ought never to be subjected to the dead-weight of the body.* The patient should take as much out-door, foot, or horse exercise as her strength will allow; but when not moving, she ought to be lying down on the floor, or on any convenient hard couch, and not sitting or standing upright. 3. A gentle course of gymnastic exercises, calculated to bring the left arm into play, may be useful. 4. Mechanical support may be required in severe cases; and the best way of applying it seems to be by a circular well-padded iron girdle, to be buckled round the pelvis, to which is attached a crutch, by which the axilla of the depressed side can be supported and gradually raised, whilst a broad band passes over the convex side of the chest, and forces it back into its proper position. The author has devised a chair, with supports for the shoulders, so that they can be kept at the same level, and in the same vertical plane; whilst it allows of free motion of the body backwards and forwards.†

II. ANGULAR CURVATURE (*Pott's Curvature*) is produced by softening and absorption, or caries of the bodies of the vertebræ—a disease which generally affects scrofulous children or adults. It usually begins with symptoms that indicate irritation of the spinal cord, such as weakness, coldness, and numbness of the legs, and incapability of taking exertion; and these symptoms are followed by twitchings and spasms of the legs, and afterwards by palsy. The bowels are costive; and there is difficulty sometimes of passing, sometimes of retaining, the urine, which is generally pale and alkalescent. Children rarely complain of much pain or tenderness in the back; but if the patient is an adult, there is generally a heavy dull aching pain, aggravated by motion, together with great tenderness on pressure; and a peculiar dead sickening sensation like that of a carious tooth, if a smart blow be struck on the diseased part with the knuckles. Great distress is sometimes caused if the patient seats himself quickly (or bumps down into a chair, as the vulgar say), so as to shake the spinal column; and this will sometimes elicit a complaint from children, who give no other sign of pain or tenderness. If the disease is situated in the dorsal vertebræ, it will moreover be accompanied with tightness of the chest, and difficulty of breathing; and if in the cervical, one or both arms may be palsied, and there will be a difficulty of supporting the head, which the patient steadies with his hands whenever he moves about. As the disease advances, the trunk becomes curved forwards, and the spinous processes of the diseased vertebræ project backwards; so as to cause great deformity. Perhaps abscesses, of the chronic scrofulous sort, form, and if so the patient will exhibit great constitutional derangement and hectic.

Consequences.—1. In favourable cases, the diseased bones collapse

* Jackson, the pugilist, used to say that he knew an infallible plan for making any child crooked; viz., Let it bolt its victuals and stand on one leg. Mayo's Philosophy of Living.

† It is made by Spratt, of Brook Street, Hanover Square.

and are anchylosed, as after ulceration of the cartilages of joints; abscesses, if they form, are healed, or their matter is absorbed; and the patient recovers in two or three years, with more or less deformity, which is of course incurable. 2. In some fatal cases the patient dies suddenly from two or three of the diseased vertebræ giving way, and crushing the spinal cord; or from dislocation of the odontoid process, owing to ulceration of its ligament; or from the bursting of abscesses into the spinal cord; or from their bursting into the pleura or peritoneum; but more frequently death is caused by slow irritation and exhaustion, consequent on the formation and bursting of psoas or lumbar abscesses.

Diagnosis.—This affection must not be confounded with hysteria. It may readily be distinguished from the distortion which arises from debility by noticing that the curvature is abrupt and angular, whereas in the latter affection it is gradual and rounded, and implicates nearly the whole spine.

Treatment.—1. *Rest* in the horizontal posture is absolutely necessary. But the patient must not be taught to lie on his back, nor must any means be used with a view of straightening the spine, as they would merely impede the natural process of recovery, by preventing the remains of the diseased vertebræ from falling together. A bandage containing strips of whalebone, and reaching from the head to the hips, is of use in keeping the trunk at perfect rest. 2. *Issues* may be made and kept open with caustic on each side of the spinous processes of the diseased vertebræ, if there is any irritation of the spinal cord. In scrofulous cases they do no good. *Leeches* may relieve occasional accessions of pain or tenderness. 3. At the same time, the constitution must be thoroughly supported by good diet, and by cod-liver oil, sarsaparilla, phosphate of lime, F. 201, or bark with lime-water, and steel, and other tonics and alteratives, as directed for scrofula. 4. Efficient mechanical support during convalescence is necessary.

III. Lumbar and Psoas Abscess.—These are abscesses arising commonly from that diseased condition of the spine which has just been described, although abscesses may occur in the same situation from constitutional debility and other causes, without spinal disease. When the connexions of the various muscles and fasciæ and the relations of the great nerves to the spine are considered, the variety of courses which these abscesses take is very intelligible. Sometimes they *point* in the back (constituting *lumbar abscess* if low down); sometimes the matter makes its way between the abdominal muscles, and may *point* at any part of the abdominal parietes; sometimes it enters the sheath of the psoas muscle, passes downwards in its sheath generally along the course of the anterior crural nerve, causes absorption of that muscle, and points below Poupart's ligament, forming a tumour which diminishes or disappears when the patient lies down, and receives an impulse on coughing. This is called *psoas abscess*. In some few cases it does not extend below Poupart's ligament, but can be felt through the abdominal parietes as an oblong tumour in the situation of the psoas muscle: in other cases it extends downwards into the thigh, on the outer side, or

in front of the femoral vessels. Sometimes it reaches as low as the knee; sometimes passes backwards to the nates; sometimes through the pelvis and sacro-sciatic notch to the nates; and sometimes it has discharged itself through the bladder or rectum.* It all cases of doubtful diagnosis the evidence of disease of the vertebræ, and of rigidity of the psoas muscle, or of inability to hop on the leg of the diseased side, or to extend it fairly on the pelvis, or to turn the toes inwards, should be looked for. The diagnosis is further alluded to in the Chapters on Aneurysm and Hernia.

Treatment.—The first indications are, to procure absorption of the matter, to keep up the health, and to remedy the spinal disease. If the tumour enlarges, and threatens to burst in spite of these measures, it must be treated in the manner directed for *large chronic abscess.*

IV. ACUTE OR SUBACUTE INFLAMMATION of the spinal cord may be caused by blows, by twists, or other injuries, and may occur during acute rheumatism; moreover, it not unfrequently attacks persons who are greatly exposed to cold and wet, such as labourers and prostitutes. It is not uncommon in hot climates in the form of peculiar diseases, called *barbiers* and *beriberi.* Fever, violent pain in the back, and complete paraplegia, with loss of power over the rectum and bladder, are the symptoms. The treatment must consist of bleeding or cupping; calomel to affect the mouth, and subsequently blisters and warm baths. In subacute and chronic cases the iodide of potassium; with colchicum or alkalis if indicated by the state of the urine; or the bichloride of mercury with tincture of bark, F. 87.

V. SPINA BIFIDA, or *hydrorachitis*, is an affection in which the spinous processes and laminæ of some of the vertebræ are cleft or deficient. The spinal membranes, deprived of their ordinary support, yield to the pressure of the sub-arachnoid fluid which they contain (which also is secreted in unusual quantity), and bulge out, forming a fluctuating tumour in the middle line of the back.

Pathology.—This affection evidently has its origin in the earliest stage of fœtal existence, and depends on an arrest of development of the neural arches of the vertebræ, and generally of the lumbar and sacral. It is found, on dissection, that not merely the spinal membranes are distended, but that the nerves may have very important connexions with the sac, which is usually formed by a distension of the folds of pia-mater and visceral arachnoid, investing the branches of the *cauda equina*—below the termination of the cord proper.

This is well illustrated by a preparation in the St. George's Hospital

* See Stanley, op. cit., p. 331. Mr. Stanley points out the diagnosis between the psoas abscess and the *iliac* abscess; which latter is a collection of matter in the cellular tissue between the peritonæum and the fascia and iliaca, or between that fascia and the iliacus muscle. It generally arises from cold, strains, or falls, or from general debility; sometimes from spinal disease, but it is not so regularly connected with the last cause as psoas abscess is. It generally attacks adults, and often women after parturition. It usually points *above* Poupart's ligament, near the anterior superior spine of the ilium; and the difficulty of extending the thigh, so constant in psoas abscess, is absent.

Museum, made by Mr. Hewett, who kindly obtained permission for the author to have this drawing made. The patient was five months old,

and died under Mr. Tatum's care. The cavity of the tumour is seen to be intersected by the branches of the cauda equina. The nerves passing out of the spinal canal at the upper part of the opening, run across the cavity of the tumour to its posterior wall, where they are firmly fixed, the nerves being here flattened and spread out upon a fine membrane. From the sac, the anterior branches of the first four sacral nerves return in distinct bundles, forming large loops, to the anterior sacral foramina, through which they pass as usual to form the sacral plexuses. The fluid had evidently been effused between the visceral arachnoid and pia-mater; and the walls of the sac were formed by the visceral and parietal arachnoid and by the skin, all of which were much thickened, and firmly united to each other.

In cases like this in which the nerves pass *through the cavity* of the tumour, it is probable that the fluid was originally in the *subarachnoid* cellular tissue, after *partial* adhesions had formed between the nerves and the two layers of arachnoid covering its posterior surface. But in some cases the nerves are found spread out upon the posterior wall of the sac, without passing *through* its cavity; and in these most probably the fluid was effused into the subarachnoid cellular tissue, after *extensive adhesions* had united the cord and its nerves to the two layers of arachnoid covering its posterior surface. Whereas, if the fluid be

effused into the cavity of the arachnoid, before any adhesions form between the two layers of that membrane, no nerves will, in Mr. Hewett's opinion, be connected with the sac.

Terminations. — The tumour formed by a spina bifida may vary in size from that of a turkey's egg to that of an adult head; and its integuments may be thick and covered with a dense cuticle, or may be thin and transparent. In some cases the tumour bursts during the act of birth; in most others, after the patient has lived some months or years, it becomes enormously distended, and ulcerates, the patient speedily dying of the irritation. In one case, of a young woman, aged 27, which came under the author's observation some time ago, and which was afterwards under the care of Mr. Walsh, the tumour relieved itself when distended, by the exudation of a watery fluid through a minute aperture. In some few cases the patient lives to the ordinary span of life, without being troubled with the deformity. There is, further, a great variety in the amount of inconvenience attending it. Sometimes it is combined with congenital hydrocephalus; sometimes with club-foot; sometimes with more or less palsy of the legs, or incontinence of urine (which symptoms are easily accounted for by the wasted and compressed condition in which the cord and its nerves are often found), whilst in other cases there are none of these inconveniences, unless the tumour is compressed or inflamed.

* Represents the tumour formed in spina bifida. From the King's College collection.

Treatment.—We have been thus minute in describing the real nature of this disease, in order to deter the surgeon from hazardous attempts at curing what must almost inevitably be an incurable malady. We read of cases in which the tumour has been cut off, and the edges united by twisted suture; or, in which it has been included in a ligature and tightly tied; but these plans will not be readily adopted by any one who would rather not open the spinal membranes, or injure the *cauda equina*. The operation of puncture, too, is generally followed by speedily fatal results. Therefore, we think the surgeon's wisest plan is, merely to apply moderate support by means of a hollow truss,

or some such contrivance, so as to counteract that tendency to effusion which there always is when the natural support of any part of the body is taken away.* If the swelling increase very fast, and the surgeon is inclined to try the effect of a puncture, he should, at all events, strictly observe the following rules laid down by Mr. P. Hewett.

1st. "The tumour should never be punctured along the mesial line, especially in the sacral region; for it is generally at this point that the cord and its nerves are connected with the sac. The puncture is to be made at one side of the sac, and at its lowest part, so as to diminish the risk of wounding any of the nervous branches.

2nd. "The instrument ought to be a needle or a small trochar; for, if a lancet is used, there will be a greater risk of wounding some important part contained in the cavity of the tumour."†

After puncture, very great attention should be paid to proper support by bandages.

VII. CANCER of the Spinal Column. When severe and continued pain in some part of the spine, with more or less derangement of the nervous functions, and perhaps some perceptible tumour, occur in a patient affected with cancer, the probability is, that some of the morbid growth is deposited in or near the vertebræ.‡

SECTION II.—INJURIES OF THE SPINE.

I. CONCUSSION.—Violent blows or bendings of the spine are liable to produce very serious injury to the spinal cord. Sometimes they cause an immediate paralysis of the parts below the seat of the injury, which gradually passes off, and thus resembles the effects of concussion of the brain; sometimes they are followed by inflammation, which requires prompt antiphlogistic measures, in order to avert permanent paraplegia or death.

II. EXTRAVASATION OF BLOOD.—A severe blow on the back sometimes causes an extravasation of blood into the spinal canal, which, as it increases, causes compression of the cord and paraplegia.

III. DISLOCATION AND FRACTURE.—Dislocation of the spine is rare, except in the cervical region; but it occasionally does occur even in the lumbar and dorsal without any accompanying fracture. When fracture occurs, it generally passes transversely across the body and arch of the vertebræ. The ill consequences of these accidents will, of course, be proportioned to the amount of injury inflicted on the spinal cord; and if that escapes compression, the consequences may not be serious. Thus it may happen that one or more spinous processes may be broken off; or that the cervical vertebræ may be twisted round; and the last dorsal and first lumbar vertebræ have been displaced back-

* See a successful case treated by Sir A. Cooper in this way, Med. Chir. Trans., vol. ii.

† See Cases of spina bifida, with remarks by Prescott Hewett, Lond. Med. Gaz., 1844.

‡ Cæsar Hawkins, Med. Chir. Trans., vol. xxiv.

wards, the patient recovering with permanent deformity, but nothing worse.*

But it more frequently happens in fracture and dislocation of the vertebræ, that the spinal cord is compressed or lacerated, and the parts below the seat of injury deprived of their nervous influence; and in these cases the symptoms vary, according to the level of the injury.

If the injury affect one of the *lumbar* or *lower dorsal vertebræ*, the legs and lower part of the trunk are palsied and insensible, the penis is erect, the fæces are discharged involuntarily, owing to palsy of the sphincter ani; but the urine cannot be voided voluntarily, owing to palsy of the muscular coat of the bladder. Immediately after the injury, the secretion of urine is diminished, but in a few days it becomes copious, ammoniacal, and offensive, and the mucous coat of the bladder inflames, and secretes a quantity of viscid adhesive mucus. The bowels are distended with wind, and obstinately costive; in protracted cases the evacuations become black, treacly, and extremely offensive. The temperature of the palsied parts at first rises—in one case so high as 111° F.—but afterwards sinks to the natural level, or below it. In some few cases, in which the spinal cord is not entirely compressed or lacerated, the patient may retain some degree of sensation or motion, or may suffer from painful spasms of the legs; but in general the loss of feeling and motion is complete.

If the fracture or dislocation be *high in the back*, or at the *lower part of the neck*, there will, in addition to the above symptoms, be palsy of one or both arms, and great difficulty of breathing, especially of *expiration*, because the intercostal and abdominal muscles are palsied, and the diaphragm has no antagonist.

If the injury be *above the origin of the phrenic nerve* (fourth or fifth cervical) the diaphragm will be palsied, and death instantaneous. The most frequent example of this is the dislocation of the odontoid process, which is sometimes caused by ulceration of its transverse ligament, sometimes by blows on the back of the head, or by lifting a child up by the head.

* Guérin, L'Expérience, Dec. 3, 1840; Shaw, Med. Gaz., vol. xvii., p. 936.

IV. SOFTENING is a frequent consequence of concussion or laceration of the spinal cord. The affected part becomes pulpy and diffluent, without, however, any traces of inflammation.

V. ACUTE INFLAMMATION of the spinal cord is a very rare consequence of injuries, except penetrating wounds, which generally prove speedily fatal in consequence. It is known by rigors, delirium, twitchings, and numbness of the limbs; difficult and quick breathing; tympanites of belly; followed by paralysis of legs, possibly of arms; perhaps general convulsions and coma. Suppuration has been found along the whole of the spinal canal, and the pus has been known to make its way along the sheaths of the nerves, so as to form considerable collections amongst the muscles.*

Prognosis.—If a fracture is situated high up, so as to affect the respiration, the patient rarely survives more than a day or two. If it is situated in the lower part of the back, or loins, he may live two or three weeks, or a month; and, in some rare cases, recovery has even occurred, of course with permanent paraplegia. The manner in which death occurs after these injuries is from general exhaustion and debility. The appetite and digestion fail; a weakening diarrhœa comes on, and then the nates slough, and the patient soon sinks. The prognosis is very uncertain after severe blows; sometimes the patient lives and recovers the use of his limbs even after complete paraplegia; sometimes life is saved but with permanent paraplegia; sometimes, on the other hand, the patient having appeared to recover from the ill effects of the injury, most unexpectedly becomes paralytic, and dies from slow disorganization of the cord.

Treatment.—1. If there be any displacement, an attempt may be made to reduce it by extension. In partial dislocations of the neck, however, the attempt should be very cautious indeed, since, although it has succeeded (in the case of M. Guérin for instance), it has also been known to produce instant death. 2. The patient must be kept at perfect rest in the horizontal posture, and the greatest care must be taken to prevent or delay gangrene of the nates, by arranging pillows or India-rubber water-cushions. 3. The urine must be drawn off by the catheter, and the bowels be kept open by clysters and purgatives, to which Sir B. Brodie recommends ammonia to be added. Tonics and the muriatic acid may be given to support the strength, and obviate the derangement of the urine. The tympanitic state of the belly may be relieved by rubbing it with the compound camphor liniment. 4. Cupping may occasionally be employed if there are inflammatory symptoms, and the pulse is firm. But in the majority of cases, if fracture has occurred, and the cord is injured, loss of blood is contra-indicated by the pulse, and would hasten a fatal issue. 5. If the patient recover with his life, any remaining weakness or palsy may perhaps be attempted to be removed by the cautious use of blisters or

* See case of latent fracture of spine, proving fatal by suppuration within the vertebral canal, by Mr. Simon, Pathological Trans., vol. vi. Dr. Bristowe, *ib.*

issues, friction, warm bathing, and the internal use of nux vomica; but they will very rarely do any good.* 6. An operation for cutting down on the fracture, and cutting out the arch of that vertebra or vertebræ which presses on the cord, was performed forty years ago by Line, and Astley Cooper. The results were not lucky, but the idea has been revived by Brown-Sequard.

CHAPTER XII.

INJURIES AND DISEASES OF THE EYE.

SECTION I.—INFLAMMATION OF THE EYE GENERALLY.

1. THE EYE is a very complex organ, containing very many different structures of great delicacy and minuteness. The effect of disease on each of these parts and structures requires to be considered separately; yet the student should be aware that he may not find in actual practice that the various diseases ending in *itis*, such as choroiditis, or sclerotitis, have such nicely-defined differences as are often assigned to them in books. For instance, it is a most arbitrary assumption that the choroid can be inflamed apart from the retina, or the retina apart from the choroid; still more to talk of congestion of the one, and inflammation of the other. No doubt there are many instances of isolated affections even amongst the most minute textures, as we shall show presently. But the first grand distinction the student must draw, is between inflammation of the conjunctiva, popularly, but falsely called *ophthalmia*, and inflammation of the eyeball. The conjunctiva, including that which covers the cornea, is a mucous membrane, subject to inflammation with mucous or purulent discharge, smarting or scalding pain, and more or less sensitiveness to light. This may be caused by various derangements of health; by long application with bright light; by atmospheric influence; or by the application of irritants, of which gonorrhœal pus is the most intense. It may lead to opacity and ulceration of the cornea, but be quite unattended with disease of the interior of the eye, and is greatly under the control of local astringent applications. In very severe cases, however, the deep-seated parts are apt to be implicated in the vascular action, although they may escape occasionally from the ravages of disease.

II. INFLAMMATION OF THE EYEBALL, on the contrary, is attended with quite a different set of symptoms;—those, in fact, which, as Dr. Jacob observes, are commonly ascribed to *iritis;* as if the iris were the only tissue concerned, whereas, in reality, in iritis, all the inner structures of the eye are more or less involved. The *symptoms* are, a bright pink arterial tint of the sclerotic; the iris altered in colour, first

* Vide Cooper on Dislocations, and Brodie on Injuries of the Spinal Cord, in Med. Chir. Trans., vol. xxi.

from increased vascularity, next from effusion; the pupil irregular, its contractile and expansive power diminished; dimness of vision; no great intolerance of light; pain, not scalding, but aching, or neuralgic, and of various degrees of intensity. Loss of transparency in the cornea, especially of the posterior elastic lamina, adhesions of the iris to the crystalline capsule; opacity of the lens and its capsule; softening of the inflamed cornea or sclerotic, so that they bulge under the pressure of the liquid within, fluidity of the vitreous humour, complete paralysis, or permanent bulging of the iris; loss of healthy structure of the retina, and various changes in the choroid, and effusion between it and the retina, are among the consequences of protracted subacute or chronic inflammation. Of the acute inflammation, attended with intensely agonizing pain, swelling of the eyelids, chemosis, flashes of light, and hot scalding tears, the consequence may be not merely effusion of lymph, with loss of transparency of the cornea and lens, but suppuration within the eyeball, indicated by shiverings, most acute pain, and a yellow distended cornea; which in such a case sloughs, if not slit open by the surgeon.

Causes.—Inflammation of the eyeball may be—1, *traumatic*, that is, caused by injuries; 2, *idiopathic*, or caused by various morbid states of the blood.

1. The first, or traumatic form, may be caused by various injuries, especially blows and wounds; but the liability to it, and the severity of it will be greatly increased by intemperance, or any other circumstance which deranges the general health. The *symptoms* will be those which we have already enumerated, in various degrees of severity, attended with furred tongue, quick pulse, headache, and fever. The *treatment* embraces all the points treated of in the Chapter on the Treatment of Inflammation in general. First, the causes—foreign bodies, chemical irritants, and the like—must be removed if possible. Secondly, soothing measures must be adopted to allay disturbed sensation:—perfect rest of the eye, and if there be a wound of the eyeball, the eyelids should be closed by a narrow strip or two of court plaster; opium, to allay pain and to insure repose of body and mind; application to the injured part either of a bit of soft, dry, old cambric, or of a fold of rag dipped in cold water and frequently renewed; or of linen dipped in warm water, or in a warm decoction of poppies, whichever the patient finds most soothing; for if the one does not suit, the other must be tried. Thirdly, eliminatives; such as a good dose of calomel and colocynth with rhubarb and carbonate of potass, so as to drain the blood of cacoplastic matters. These complete the preventive measures. But if, notwithstanding, inflammation does come on, then, fourthly, the afflux of blood must be checked. If the patient is able to bear it, venæsection may be performed. If not, from eight to twelve leeches may be applied to the temple, or cupping. The fourth indication will also be assisted by the use of saline purges, and saline draughts with small doses of tartar emetic. Fifthly, should the preceding measures not check the disease, or should bloodletting be con-

sidered inapplicable, mercury should be given gently, as directed for iritis, so as to control the effusion, or cause it to be absorbed. Lastly, the diet should be proportioned to the patient's strength, but not too low. The eyes should be protected from light; yet without sacrificing good ventilation and coolness. As the disease is disappearing, bark will often be of material service.

2. Of the various idiopathic inflammations of the eyeball, we will mention (*a*) that most *foudroyant* attack, which sometimes occurs in *pyæmia*; in which the eye is filled with unhealthy lymph, and destroyed with a rapidity that admits of scarcely any remedy. See *Pyæmia*. (*b*) Inflammation of the eyeball as a consequence of contamination of the blood from the poison of *syphilis*, is described under the head of *syphilitic iritis*; (*c*) that caused by rheumatism, common or *gonorrhœal*, is described under the heads of *sclerotitis*, and of *rheumatic iritis*. (*d*) *Scrofulous* affections are spoken of under the head of scrofulous iritis, and corneitis; and of cancer of the eye, Sect. 18. Strumous ophthalmia, commonly so called, is a disease of the conjunctiva, so far as it is a local disease at all. Lastly, one eye may be affected sympathetically by disorganization of its fellow; a thing to be averted by removing the cornea and evacuating the morbid products, or extirpating the eye after the manner of Bonnet.*

SECTION II.—INJURIES.

I. WOUNDS of the eyelids or eyebrows should be most carefully adjusted by means of sutures, introduced with a very fine needle, which should pass through the cartilage, if divided. The glover's needle is the best. The greatest care should be taken to prevent irregular cicatrization, with the distortion, and inversion or eversion, that may be the result of it. A linen rag wetted with cold water should then be laid on the part—inflammation should be counteracted, and the patient be kept at rest till the wounds are healed. Wounds of the forehead, but more especially of the eyebrow, and of the margin of the orbit, even though the globe of the eye has not been struck, are occasionally followed by loss of vision, owing to concussion of the retina, or effusion of blood in the eye.

II. BLOWS on the eye are generally followed by a disreputable-looking ecchymosis, which is inconvenient enough. But sometimes a blow on the naked eyeball, even when so slight as to leave no trace of injury, or a severe blow on the temple, causes detachment of the retina, or some other deep-seated injury to the eye, dimness or total loss of sight, which, when neglected, may lead to permanent blindness.

* See a series of cases by Haynes Walton, illustrating this point, Med. Times, Feb. 18th, 1854; and similar cases by Mr. R. Taylor, Ibid., Oct. 28th, 1854. The author most strongly recommends the perusal of a Treatise on Inflammations of the Eyeball, by Arthur Jacob, M.D., &c., Dublin, 1849.

For the prevention and treatment of ill-consequences, refer to the Section on Inflammation of the Eyeball generally.

Blood effused into the chambers is generally absorbed in the course of a fortnight, if inflammation be kept down. If coagulated firmly, it will take much longer, even months.

Rupture of the eye may be caused by a violent blow. Extreme quietude and care should be taken to save any remnant of sight, and to avert dangerous inflammation.

Dislocation of the crystalline lens is another possible result of a severe blow. If driven into the anterior chamber, and if the patient is young, and if it gives no trouble, it may be left to nature, especially if there be reason to think that the capsule does not surround it. If, however, it becomes irritating, or if the patient is above forty, it should be removed. If dislocated into the posterior chamber, it will almost certainly produce disorganization of the eye, if not removed by extraction; and it may be well to bring it into the anterior chamber by means of a needle, before the removal.

III. FOREIGN BODIES. When a patient complains of a foreign body in the eye, the surgeon should first examine the cornea; then the inside of the lower eyelid and lower part of the globe, by everting the lid, and telling the patient to look up. If nothing is discovered there, the patient should turn the eye downwards, so as to expose the upper part of the globe, and the surgeon should turn the upper eyelid inside out, which may easily be done by taking the eyelashes between the finger and thumb, and turning the lid upwards over a probe. If any substance stick in the cornea, so that it cannot be removed by a probe, or silver toothpick, or fine forceps, the point of a cataract needle or lancet should be carefully passed under it so as to lift it out. A still more effective instrument is a sort of delicate scoop or gouge, introduced by Haynes Walton; for foreign bodies, when sharp and angular, and particles of hot iron often become so imbedded in the cornea, that they must be scooped out. Perfect rest to the eye should be enjoined, and every other means be taken to obviate inflammation. To remove particles of lime or mortar, the lids should be everted, and the eye be well syringed or sponged with weak vinegar and water, or with oil, or with pure water, if neither be at hand. For injuries with acids or alkalies, ablution or syringing with water is the readiest remedy. We may observe that whenever there is an inflammation of the conjunctiva, with a fair probability that it may have been caused by the intrusion of a foreign body, the strictest and most accurate search should be made; because an eye might be lost, or the patient subjected to weeks of illness, and of ineffectual treatment, if it were allowed to remain. Whenever a foreign substance has passed within the anterior chamber, if it can be seen and readily seized, it is better to extract it at once, if the

* Gouge for removing foreign particles from the cornea.

on possess the requisite skill and instruments, which are those ed for the extraction of cataract. Mr. Bowman finds a drop of -oil the most soothing application in those very painful cases, in the epithelium has been scratched or roughly stripped off from rface of the cornea.*

. PROLAPSE OF THE IRIS, in consequence of penetrating wounds cornea, may be attempted to be reduced by closing the eye, and gently rubbing the lid against the cornea, so as to press on the ed portion, and afterwards by exposing it to a strong light, so cause the pupil to contract. Or a solution of atropia, F. 198, the extract of the Calabar bean, may be applied to the con-va, and this, whether a portion of the pupillary margin be or be rolapsed. In either case, if dilatation or contraction can be d, there may be a favourable issue. Mr. H. Walton relates an ce in which reduction was effected by means of a probe. Dr. enzie thinks that if the little bag of iris were emptied of its us humour, it would often return immediately to its place, and ts an attempt to empty it by pressure. Unless the reduction can tempted immediately after the prolapsus, all chance of returning last, because it soon becomes strangulated. When the prolapsed annot be returned, some surgeons have advised that it be snipped st it irritate the eye; but in doing so there is *likelihood of pro-g further protrusion*. In some rare accidents when a a large part arly the whole of the iris hangs out, it may be prudent to remove t; but, generally, the safer plan is to let it remain; all that is equired to plug up the opening will very soon be removed spon-usly. The protruded part, says Mr. Walton, rapidly cicatrizes with a partly opaque, and partly transparent cicatrix. Any cation (such as the lunar caustic formerly recommended) interferes the natural process.

SECTION III.—DISEASES OF THE EYELIDS.

HORDEOLUM, or sty, is a small painful boil at the edge of the l, having most probably its seat in a ciliary follicle.

Treatment.—Poultices or fomentations; subsequently ung. hydr. l. dilut., to remove any remaining hardness. Aperients, and vards tonics and alteratives, are always necessary, as the com- always arises in debilitated constitutions.

OPHTHALMIA TARSI is an inflammation of the palpebral con-va and the edge of the eyelids, with disordered secretion of the mian glands—so that the eyelids stick together, and become ted with dried mucus during sleep. It may be *acute*—attended great pain and soreness,—but in general it is chronic and obsti- and attended with itching. It commonly occurs to weakly s with disordered digestive organs. It may lead to ulceration of

* Bowman, Lectures on the Parts concerned in the Operations on the Eye, 1849, p. 120.

the eyelids, disease of the hair follicles, and loss of the lashes; sometimes to thickening and subsequent inversion of the edge of the lids.

Treatment.—In the first place, the health, which is always out of order, must be remedied by aperients, alteratives, tonics, change of air, bathing, and whatever other measures may be suitable for each particular case. Whilst there are much heat and swelling, the eyes should be bathed with an anodyne collyrium, F. 142, and the edges of the lids be smeared with lard at bedtime to prevent them from sticking together. But so soon as the bowels have been well cleared, an astringent collyrium, F. 140, may be used during the day, and the diluted unguentum hydrargyri nitratis be applied in very small quantity, with a small camel's-hair brush, to the edges of the lids at bedtime, F. 168. The lashes should be plucked out if there is any ulceration about their roots. Mr. Walton generally cuts them off even in the early stage of the affection, as this facilitates cure by enabling the applications to be more effectually made.

III. SYPHILITIC ULCERS of the eyelids, if primary, will be known by their sudden appearance in a patient otherwise healthy, and by their not having been preceded by a wart or tubercle, like cancerous or epithelial ulcers, and by the results of inoculation. Secondary ulcers will be known by their coppery colour, and the general cachectic look of the patient, and presence of secondary symptoms in other parts.

Treatment.—The treatment of syphilis generally.

IV. TRICHIASIS signifies a growing inwards of the eyelashes. Sometimes the lashes which turn in, seem to constitute a second or distinct row, and the term *distichiasis* has been applied to this state. Mr. H. Walton has shown, however, that the appearance of this supposed independent row is a deception, and depends on the isolated position of the innermost lashes when inverted. *Causes.*—It seems to depend on some changes in the fibro-cellular tissue in which the cilia follicles lie, produced by irritation. The disease is exceedingly common amongst the lower orders, especially the Irish. *Treatment.*—If plucking the lashes proves ineffectual, an operation must be resorted to; and three are enumerated by Mr. Walton. One consists in the excision of a portion of skin from the lid, so as to give a sufficient outward tendency to the whole lid, to keep the inverted lashes away from the globe. An incision is made through the skin of the lid close and parallel to the lashes. A second incision is made to meet the extremities of the first, and to include an elliptical portion of skin between them, which is next dissected out, and the edges brought together by sutures. The other operation consists in the extirpation of the roots and bulbs of the offending lashes. An incision is first made along the edge of the lid through the skin, corresponding to the lashes that are to be removed. Two other short cuts are then made at each end at right angles, so as to form a small flap, which is to be lifted, and the bulbs of the hairs most carefully dissected off the cartilage. The skin is then to be laid down, and retained by a stitch. The third is a last resource, and must be

s an extreme measure, and when there is so much thickening dge, and so much irregularity of the lashes, that neither of will suffice. It is to dissect away the hair follicles from the l border.

TROPION has been attributed to a variety of causes, among be mentioned contraction of the ciliary margin of the lid, of the conjunctiva at the line of reflection from the lid to ontraction of the entire tarsal cartilage, and redundancy of the lids. Mr. Wilde has endeavoured to show that it is traction of the conjunctiva *lining* the lid. Mr. Haynes ributes its *immediate* cause to the unnatural action of that the orbicularis palpebrarum muscle, which covers the edges al cartilage, and which he states to be thicker, and more n any other portion of the muscle that is on the cartilage. le shows that the operations usually undertaken for the entropion, such as the division of the tarsal cartilage per- y at each angle, and suspending the lid after Crampton's der the idea of the contraction either of its edge or body; val of any portion of the conjunctiva; or the cutting off the lundant skin—do not answer; and recommends the plan of the cilia, leaving, however, the cartilage entire.

he other proofs that Mr. Walton adduces, of the power of portion of the orbicularis muscle to act in the manner he the fact, that a colleague of his can invert his lids by the the will alone. He proposes, therefore, the removal of the ion of the muscle so as to destroy the inverting power, and of a portion of the skin of the lid to overcome whatever the tarsus may have acquired. Simple division of the lid slit has been recommended, and is adopted by some sur- Mr. Walton says that this operation, by destroying the per- n of the orbicularis, may in some instances answer, *i. e.*, arsus has not acquired any permanent curve, but in the ty it will not, it being addition to remove skin of the lid also. on is made along the tarsus, and close to its argin, from one angle to the other; and a rly parallel to it, lines distant, and its extremities; the carried down to the rough both skin and en one corner of this ised by forceps, it is

cut represents an ectropion caused by a cicatrix; the second shows results of the operation spoken of in the text.

dissected clean off the cartilage, and the edges of the wound brought together by sutures.*

VI. Ectropion, or eversion of the eyelid, may be caused, 1. By a *thickening of the conjunctiva*, owing to long-continued inflammation. The weak ung. hydr. nitric. oxyd., or lotion of arg. nit. (gr. ij. ad ℥i.), may be tried first, in order to bring the conjunctiva into a healthy state; but if they do not succeed, a portion of the thickened conjunctiva must be removed by a careful dissection along the edge of the lid; so that the parts may be braced up by the contraction that ensues: and it may be necessary besides to cut out a triangular slip from the tarsus. In the aged, the eyelid falls down from paralysis, and the exposed conjunctiva becomes thickened. 2. It may be caused by a *cicatrix on the cheek*,—that resulting from a burn, for instance. But by far the most common cause is the cicatrization resulting from the healing of abscesses at the edge of the orbit. Various operations have been suggested and practised for its removal, one of which consists of the removal of the cicatrix, and the subsequent transplantation of a portion of skin from the temple or the cheek, after the manner described in the observation on lost noses. It is a simpler and better plan to *transpose* the skin, as Mr. Walton calls it,—that is, to separate it freely to a considerable extent around, draw it to the position required, and retain it by sutures. It may also be necessary to remove a wedge-shaped portion of the tarsal cartilage.

VII. Lagophthalmos (hare eye) signifies an inability to close the palpebræ. Sometimes it arises from the contraction of cicatrices, and requires the same treatment as ectropion, when arising from the same cause. But it sometimes depends upon inaction of the orbicularis muscle, through palsy of the portio-dura; so that the levator palpebræ being unopposed, keeps the eye open. This may be caused by exposure to cold—on the outside of a coach, for instance: in which case it is attended with numbness of the cheek, and generally subsides in a few days with aperients, nursing, and perhaps a blister behind the ear. But it may be caused by a tumour in the course of the nerve; by disease of the part of the temporal bone through which it passes; or by congestion within the head, like the following disease:—

VIII. Ptosis signifies a falling of the upper eyelid from palsy of the third nerve. Sometimes it is attended with headache, giddiness, and

* Vide Wilde on Entropion and Trichiasis, Dublin Journ. Med. Sc., March 1844; Haynes Walton, Operative Ophthalmic Surgery, Lond. 1853, p. 187.

other signs of congestion in the head, which should be treated by bleeding, purgatives, and blisters. Sometimes it arises from debility, and may be removed by tonics. Sometimes it is an accompaniment of that form of amaurosis which arises from organic cerebral disease; and is attended with dimness of sight, a sluggish dilated pupil, and more or less strabismus: the eye being turned outwards and downwards because the external rectus and superior oblique are the only muscles unparalysed. If it occurs without any assignable cause, and persists, notwithstanding the employment of every measure calculated to improve the health, a portion of skin must be taken out from the eyelid, so that the lid may be brought under the influence or action of the occipito-frontalis muscle, and be elevated by it. This must not be done, however, if, as Mr. Walton remarks, double vision should be caused by the eye being thus brought into use. This author says further, that the portion of skin to be removed must be taken near the eyebrow, else the lid may be everted, and should be dissected neatly out with a scalpel, so that there may be no scar.

IX. ANCYLOBLEPHARON.—Union of the edges of the lids, when complete and congenital (which is very rare), may be removed by an incision; when partial and consisting of a junction of the lids near one angle, which is sometimes caused by cicatrizing ulcers, it is incurable.

X. SYMBLEPHARON signifies a union of the lid to the globe, following some accident that has caused ulceration of both—the introduction of lime, for instance. It is irremediable, if the adhering surfaces are extensive. Very slight adhesions (frænæ) may be divided; but the raw surfaces are too apt to adhere again. To prevent this, Mr. Walton divides the band vertically through its entire thickness, and brings the edges of each side severally together by sutures.

XI. TUMOURS of the lids may be of many varieties. Warts, enlarged cutaneous follicles, and vascular tumours, or *nævi*, are to be treated the same here as elsewhere. Cysts of hydatids may grow beneath the loose fold of conjunctiva which passes from the inside of the eyelid to the surface of the eyeball. If that fold be divided longitudinally, the hydatid will escape, or may be extracted by a hook or forceps. There is one small tumour found here, and called, *par excellence*, the *tarsal tumour*, the true nature of which the writer has examined, in concert with Mr. H. Walton. It consists of one of the acini of the Meibomian follicles, filled by thick sebaceous matter. If it projects on the inner surface of the lid, it is readily recognized as a small darkish speck, which may ulcerate and discharge its contents. If it chance to project on the outer surface of the so-called tarsal cartilage (for it must be observed that the Meibomian follicles are not, as is usually said, on the inner surface of the cartilage, but are contained within its very substance), then the obstructed follicle, having no means of emptying itself, forms a small tumour, which increases by the addition of fibroplastic matter to its exterior. Such tumours may be felt under the skin and orbicularis, attached to the outer surface of the tarsal cartilage. On everting the lid, a slight depression is noticed within. A

sufficiently free puncture should be made from within the lid, the cyst broken up with a probe, and the sebaceous and epithelial contents be evacuated.

XII. PEDICULI.—These loathsome insects sometimes lodge about the roots of the eyelashes, and produce an obstinate itching. They are easily killed by any mercurial preparation; but the surgeon ought to be aware of their existence, as they might be mistaken for crusts of dried mucus.

SECTION IV.—DISEASES OF THE LACHRYMAL APPARATUS.

I.—THE LACHRYMAL GLAND is occasionally subject to acute and chronic inflammation—the symptoms and treatment of which will be obvious.

II. XEROPHTHALMIA signifies a dryness of the eye from deficiency of the tears, or rather of the mucous secretion of the conjunctiva. It may be palliated by the occasional application of glycerine, or of a tepid lotion of infusion of quince-seed, by means of an eye-cup. Mr. Taylor has succeeded in two instances in restoring useful vision by keeping the cornea constantly moist with glycerine.*

III. EPIPHORA signifies a redundancy or over-secretion of tears, so that they run over the cheeks. It should be distinguished from the *stillicidium lachrymarum*, or overflow of tears, in consequence of an obstruction in the channels that convey them to the nose. It may depend on general irritability of the eye, and is not unfrequent in scrofulous children. When arising from this cause it should be treated by aperients and alteratives, with tonics and antacids (F. 38, 10, 11, 20, 76, 77). An emetic may be given if the stomach is foul. The same local applications may be used as are prescribed for scrofulous ophthalmia. Search should be made for foreign bodies or inverted eyelashes.

IV. CLOSURE OF THE PUNCTA LACHRYMALIA may be congenital, in which case it is quite incurable, or it may be a consequence of inflammation of the lachrymal sac and its appendages. Of course it produces a *stillicidium lachrymarum*. When a consequence of inflammation, it is only temporary, and passes off as soon as the inflammation subsides, to which the treatment should be directed. Actual closure of both puncta, except from the cicatrization of a wound, scarcely ever takes place, and the loss of only one does not matter much if there be no accompanying inflammatory affection, and the eyelids are not displaced. The treatment to be adopted when both are obliterated, and the canaliculi are not destroyed, is, according to Mr. Bowman,† to cut across one of them close to the obstruction, and then slit up the canal on a probe. When an orifice cannot be so formed, he recommends opening the sac below the *tendo oculi*, and slitting up the canal near the ob-

* See his excellent paper on this disease in the Edin. Med. and Surg. Journ. No. 198, new series.

† Med. Chir. Trans., vol. xxxiv.

struction on a probe run into it from the sac. For this to be successful, the obstruction should be sufficiently far from the sac to allow of the canal being slit up in the interval through the conjunctiva. When this cannot be effected, there should be made an opening between the sac and the inner corner of the eye, and a fistulous aperture be established by the presence of a foreign body. To ascertain whether there is actual stoppage in the passage, Anel's gold probes may be used. Bowman has also shown that every divergence of the lower punctum from slight eversion of the eyelid, the result of chronic inflammation of the conjunctiva or disease of the skin of the lid, may produce *stillicidium*. To remedy this condition, he slits up the canal from the punctum, till the incision reaches that part of the mucous surface on which the tears collect or against which they rest.

V. OBSTRUCTION OF THE NASAL DUCT is most probably a consequence of thickening of the mucous membrane that lines it, and is, according to Mr. Walton, a scrofulous affection not uncommon in delicate young persons. The patient complains of *weakness* of one eye, which is perpetually watering; and of dryness of the corresponding nostril. The lachrymal sac distended with tears and mucus or muco-purulent matter forms a small tumour by the side of the nose, from which the contents can be squeezed upwards through the puncta, or downwards into the nose, if the obstruction be not quite complete. A case is related of complete obliteration of the bony canal of the nasal duct by bony deposit, in which a permanent opening was made from the eye to the nose.* Mr. Walton has lately met with a similar case in the person of a medical man. Obstruction mostly leads to

VI. CHRONIC INFLAMMATION OF THE LACHRYMAL SAC—tenderness of the sac, perhaps redness of the superjacent skin; irritability and constant tendency to inflammation of the conjunctiva, with mucous or purulent discharge. There is often great variation in the symptoms in the same case, especially at different seasons of the year; for there may be great suffering in winter, and scarcely any inconvenience in summer.

VII. ACUTE INFLAMMATION of the sac is known by great redness, swelling, pain, and tenderness, at the side of the nose, implicating the eye, and attended with fever and headache. The writer has seen it as a sequel of scarlet fever. If it be not soon relieved the sac will suppurate and burst.

VIII. FISTULA LACHRYMALIS signifies an ugly fistulous aperture at the inner corner of the eye, communicating with the lachrymal sac. It is the ordinary consequence of the three preceding affections, if unrelieved, and may be said to have five stages. First, it begins with *obstruction of the nasal duct*; the most prominent symptom of which is a perpetual watering of the eye. Secondly, this is followed by *inflammation*; which, thirdly, gives rise to *abscess*; and this, fourthly, by its bursting, causes the *fistulous aperture* from which the name of

* H. Walton, Med. Times, May 1846. A case is related in Forbes's Review, 641, of congenital absence of the nasal duct, in which M. Berard succeeded in establishing a communication with the nose.

the affection is derived; whilst, fifthly, in old neglec lachrymal or superior maxillary *bone may become carious* not very common. The fistulous aperture is generally fungous granulations, and the skin around is red and th the perpetual irritation of the tears that escape from it, there is considerable loss of skin.

Treatment.—Acute inflammation of the sac must b leeches, purgatives, and cold lotions or poultices. If the in severity, and become throbbing, the sac should be o manner to be presently described.

Chronic inflammation of the sac should be treated by leech; by steaming the nose so as to soothe and bring th of mucous membrane into a healthier state, and by the st tion to the general health, and especially to the function and of the digestive organs. When the sac becomes d patient should endeavour to press its contents down into t he should also frequently draw in his breath strongly whi and nostrils are closed, so as to draw the tears down th pressure of the atmosphere. The secretions of the eyeli corrected with citrine ointment (F. 168), and a few d astringent collyrium (F. 140) should be put twice a day i angle of the eye, so as to be absorbed by the puncta, and the sac. By these means the thickening of the duct ma removed, or, at all events, the patient may go on pretty c

Surgical treatment.—But if the retention of the tea causes a constant irritability of the eye, or if there is a fis between the sac and the cheek, measures should be adopt the obstructed duct. In former days this was effected by style, a silver or silver-gilt probe with a head like a nai introduced through an opening made just below the *ten* worn for some weeks, or even months. But this mode has been in a great measure superseded by that introd Bowman, who slits up the canaliculus upon a fine directo enabled to introduce directly into the sac a series of probes sizes, by which dilatation is gradually effected. As this ever, is apt to be rather tedious, Mr. Hulme, after havin canaliculus, passes a fine wire of virgin silver down the nostril, bends the edge of it over the lid, and cuts it off w nippers, leaving a hook about ¼ of an inch long hanging ex the lid, where it may be fixed by a piece of plaster. In larger wire is introduced, and so on until the largest s which will be in two or three weeks.*

IX. THE LACHRYMAL GLAND is very rarely the seat o the author is not aware of any accurate dissections or examinations: moreover, it is pretty certain that other tu outer part of the orbit have been mistaken for enlarge gland; and that a healthy gland has been occasionally r

* Med. Times and Gazette, May, 1859.

tentionally with such a tumour. Pain, preternatural flow of tears, and a lobulated tumour under the outer part of the roof of the orbit, are the symptoms; careful extirpation the remedy. See Section xviii. Sometimes this gland is extirpated, in order to get rid of the flow of tears, in cases in which the eye has been lost, and the puncta closed by burns or other injuries, so that the tears are incessantly dribbling on the cheek. An incision must be made for this purpose along the edge of the orbit, through skin, orbicularis, and fascia, when the gland will be exposed, and both portions of it must be removed; for it must be recollected that it has two lobes, and that if either of these is left, the purpose of the operator is defeated.

SECTION V.—DISEASES OF THE CONJUNCTIVA.

I. COMMON OR CATARRHAL OPHTHALMIA consists of inflammation of the conjunctiva. *Symptoms.*—Smarting, heat, stiffness, and dryness of the eye, with a feeling as if dust had got into it; the conjunctiva of a bright-scarlet redness; the redness superficial, so that the enlarged vessels can be moved by pulling the eyelids; slight intolerance of light and *flow of tears* on exposure of the eye at first, followed by a thin purulent discharge, which in severe cases becomes thick, and doubtless contagious.

Causes.—Slight local irritation, disorder of the digestive organs, or cold and damp.

Treatment.—A dose of calomel followed by black draught, and preceded by an emetic if the stomach is very foul; the eye to be frequently bathed with poppy decoction, or the weaker forms of F. 140, lukewarm or cold, according to the patient's choice; the edges of the eyelids to be smeared at night with fresh lard, and with weak ung. hydr. nit. ox. after the first day or two; a green shade to be worn over *both* eyes, if there is much intolerance of light; but the patient not to be confined to the house too long, unless the case is very severe, or the weather bad. If there is much inflammation, a large drop of solution of arg. nit. (gr. i. ad ℥i.) may be put into the eye twice or thrice a day. If there is much *pain*, leeches may be applied to the temples; and if the patient is plethoric, and there is much headache and fever, bleeding and calomel in repeated doses may be required. But it is a great mistake to treat common inflammation of the conjunctiva, when it occurs in delicate subjects, by lowering measures. After the bowels are cleared, a good diet, and exposure to moderate light and cool air, and an astringent lotion, will do more good than black draughts, leeches, and green shades.

II. CHRONIC INFLAMMATION OF THE CONJUNCTIVA may be a sequel of the acute; or may be caused by some local irritation, such as inverted eyelashes; or by some derangement of the health.

Treatment.—1. All local sources of irritation should be removed. 2. The general health should be amended, in the same manner as directed for chronic inflammation generally. 3. The distended capil-

laries must be unloaded by occasional leechings, and be excited to contract by stimulants and astringents, such as the various collyria in F. 140, &c., which should be used with an eye-cup; or the vinum opii (which Mr. Walton dilutes with an equal quantity of water), and of which a few drops may be put into the eye daily. The edges of the eyelids should be smeared every night with weak ung. hydr. nit.; and blisters should be applied behind the ears, if the case is obstinate.

III. PURULENT OPHTHALMIA, or *purulent conjunctivitis*, is a very violent form of inflammation of the conjunctiva, and is attended with a thick purulent discharge, which supervenes in from twenty-four to forty-eight hours after the commencement of the disease. There are three varieties of it:—1, the purulent ophthalmia of children; 2, the common purulent ophthalmia of adults; and 3, the gonorrheal ophthalmia.

THE PURULENT OPHTHALMIA OF CHILDREN, or *ophthalmia neonatorum*, always begins to appear a few days after birth; generally on the third day.

Symptoms.—At first the edges of the lids appear red, and glued together; their internal surface is red and villous, and the eye is kept closed. Then the conjunctiva of the globe becomes intensely scarlet and much swelled, sometimes so much so as to cause eversion of the lids; it secretes a thick purulent discharge, and the child is very restless and feverish. If neglected, this disease may occasion opacity or ulceration, or perhaps sloughing of the cornea; but it generally yields to early and proper treatment. Yet sometimes the interior of the eye is very much damaged, and the retina is left very feeble.

Causes.—In most instances in which the author has seen this disease, the mother has complained of some amount of *discharge* during her pregnancy. In some well-marked cases the husband has also had gleet; therefore it is not unfair to infer that this ophthalmia is caused by the contact of vaginal secretion during birth. Possibly irritation of the eyes from neglect of cleanliness may be a cause in other cases.

Treatment.—This disease, if submitted to early treatment, is easily cured by great attention to cleanliness, and by incessantly washing away the discharge with some mild astringent lotion. Either of the weak collyria (F. 117) will answer; and a large drop of a solution of one grain of nitrate of silver to an ounce of distilled water may likewise be put between the lids once a day with a camel's-hair pencil. The practice pursued at the Central London Ophthalmic Hospital, is to wipe away from the eye with a soft rag and warm water as much discharge as possible, then to apply with a syringe a lotion of four grains of alum to an ounce of water; after that, the edges of the lids are smeared with lard to prevent them from sticking together, and these proceedings are repeated every half-hour. Neither blistering nor leeching is resorted to. When the discharge is on the wane, the lids may be smeared at night with weak citrine ointment. The eye should be opened with very great delicacy by resting the fingers on the edges of the orbit, and then drawing open the lids in such a way as to avoid any pressure on the

eyeball; because if the cornea is beginning to suppurate, it might easily be burst, and the lens be squeezed out. The bowels should be cleared with a grain of calomel or gray powder, followed by a little castor-oil or rhubarb. If the disease has been neglected, and there is great tumefaction, a leech may be applied to the temple, and half a grain of calomel be given every eight hours, for three or four doses. If the insides of the lids become thickened, a condition called *granular conjunctiva*, which never happens unless too strong a lotion has been used, the proper plan is to leave the injured eye alone, and to lay a few threads of cotton, spread with blistering plaster, between the external ear and the head, so as to create a discharge. If the cornea ulcerate or slough, or if the discharge be obstinate, tonics are required (quin. sulph. gr. fs. —vel ext. cinchon. gr. iii. ex lacte), and the astringent collyria should be persevered with.

IV. PURULENT OPHTHALMIA IN ADULTS (*Contagious* or *Egyptian Ophthalmia*). *Symptoms.*—This disease begins with stiffness, itching, and watering of the eye, with a sense of dust in it, and slight swelling of the lids, which stick together during sleep, and on examination of their internal surface, the palpebral conjunctiva is found to be intensely red, thick, and villous, like a fœtal stomach injected. As the disease advances, the conjunctiva covering the globe becomes also intensely red, swollen, and villous, and discharges a copious secretion of pus. The swelling of the ocular conjunctiva is called *chemosis*. It is produced by effusion of serum and lymph into the cellular tissue which connects the conjunctiva to the sclerotic; and it elevates the conjunctiva into a kind of roll around the margin of the cornea, which sometimes overlaps it entirely. These symptoms are accompanied with severe burning pain, extending to the cheek and temple, and great headache, fever, and prostration; the palpebræ also are swollen, tense, and shining, so that the patient cannot open the eye.

Consequences.—This affection may lead to ulceration or sloughing of the cornea; and very commonly to some impairment of vision, from extension of inflammation to the internal parts of the globe.

Causes.—It may be produced by severe local irritation, as the introduction of lime, for instance, or a blow. It is endemic in Egypt, owing to the glaring sunshine and the particles of sand with which the air is loaded. It may also be produced by the close damp atmosphere, saturated with animal vapour that results from crowding many persons together in a confined space, and from the neglect of cleanliness and ventilation; hence, its prevalence amongst the military in barracks; in schools; and on board ship—especially amongst the wretched inmates of slave-ships. But when once produced, by any cause whatever, it is most probably both *contagious* and *infectious*; that is, capable of being propagated both by contact with the purulent secretion, and by exposure to the floating particles of pus in the air of crowded and fetid dormitories.

V. GONORRHŒAL OPHTHALMIA is the most violent form of purulent conjunctivitis. The *symptoms* are essentially the same as those

Cause.—This disease arises without doubt from the gonorrhœal matter from the urethra to the eye.

Prognosis.—This is very unfavourable. The sight eye will either be lost, or excessively impaired, unless tre early and efficacious.

Diagnosis.—If a patient applies with violent conjuncti is a suspicion that he has a clap and has infected his ey should insist on an examination of the penis, howeve patient may deny the fact of his having any disease.

Consequences.—The most frequent and detrimental *the cornea.* The sloughing generally occurs quite s cornea may be clear in the morning—cloudy and flaccid —and by the next morning it may have burst; and th supervene at any time from the second day of the disea After this has occurred, the swelling of the lids subsides diminishes and becomes thinner, and the pain greatly slough is very small, the iris may protrude, and close th perfect sight remaining,—but generally the greater part perishes; a fibrous deposit takes place on the iris, and tended produces staphyloma: and all useful sight is lost

Treatment.—There are three sets of measures which in this very hazardous disease; viz., antiphlogistic rem tions, and astringents.

If the patient applies at the very commencement, the or a nitrate-of-silver lotion several times a day, indeed e fomentations of poppy, together with a low diet, antimon ment to bed, may suffice to check the disease.

But if the disease has reached its height, and there is headache, with full bounding pulse, it may be right to means of leeches to the temples, to purge, and to admini doses of antimony, and Dover's powder, at bedtime, to al patient must be kept in bed, in a darkened room, with th

presently, do not arrest the disease, and the chemosis is evidently extending round the cornea, and the cornea is becoming hazy, incisions, at equal distances, should be made completely through the swollen conjunctiva, beginning at the margin of the cornea, and radiating towards the circumference of the eye.* "A small curved bistoury must be introduced just where the chemosed conjunctiva overlaps the cornea, and the point carried through the entire thickness of the swelling to the palpebral sinus, taking care not to injure the sclerotic coat, then the knife should be depressed, and the bistoury made to cut its way out. The incisions may be advantageously employed more than once in the same case, and are useful even when the conjunctiva is not extensively chemosed;"† but an eye may perish in spite of them, as of all other means. The patient, if unruly, should be narcotized by chloroform; if not, he should sit on a low chair, and the operator stand behind him, and raise the upper lid with a retractor, whilst an assistant depresses the lower. They should be fomented with warm water, that they may bleed. If there comes on, as frequently happens, an exacerbation of pain towards evening, it may be prevented by applying a few leeches in the afternoon, or by putting blisters behind the ears.

The eyes should be frequently but gently washed out, by means of a piece of fine sponge, or syringe, with warm water or poppy decoction, containing three grains of alum to an ounce, in order to get rid of the purulent secretion; and once or twice daily, a few drops of a freshly-made clear solution of two grains of nitrate of silver in an ounce of distilled water should be dropped into the eye by means of a camel's-hair pencil. As soon as the chemosis begins to lessen, the weaker preparations of F. 140 may be used. The diet should be improved, and the edges of the lids should be smeared at night with weak ung. hydr. nit. ox. If the strength becomes impaired, or if the cornea has given way, tonics, especially bark, F. 1, 4, should be administered, which, with repeated blisters, and a continuance of the astringent applications, are the measures for removing the relics of the disease.

VI. SCROFULOUS OPHTHALMIA (*phlyctenular ophthalmia*) generally attacks children under eight years of age, but is not uncommon in adults.

Symptoms.—The characteristic feature of this disease is the extreme *intolerance of light*; quite out of proportion to any local visible disease. The lids are kept spasmodically closed, and the head turned obstinately away from the light; yet there is no general vascularity of the con-

* This practice was revived by Mr. Tyrrell (vide Med. Chir. Trans., vol. xxi. part ii., and Tyrrell on the Eye, vol. i., p. 73). It is mentioned by Astruc in the following terms:—"It was thought proper some time ago to try the same remedy in the eye tending to a mortification, as is made use of in other parts of the body when they are threatened with the same disease; viz., to *scarify the swelled conjunctiva thick and deep*, so that the globe of the eye, and especially the cornea, might be less compressed by it; for that sudden destruction of the eye seemed to be chiefly owing to its being too tightly embraced by the swelled conjunctiva."—Astruc on the Venereal Disease, translated from the Latin. Lond. 1754.

† Haynes Walton, Operative Ophthalmic Surgery, p. 271.

junctiva, but a little line of vascularity running towards the cornea, and terminating at one or more *phlyctenulæ*, or small opaque pimples (or sometimes pustules) at the margin of the cornea. This, like other scrofulous diseases, is extremely obstinate, and liable to recur frequently.

Treatment.—The first and chief point is to look after the general health, and especially to use moderate but effectual purgation, till the bowels are emptied, and their secretions rendered healthy. Three or four doses of calomel at bedtime, on alternate nights, with rhubarb and soda, or rhubarb and polychrest salt, F. 37, in the morning, will generally relieve the intolerance of light quickly; and when the tongue is cleaning, and feverishness has subsided, recourse must be had to tonics, cod-liver oil, and to the other general remedies directed for scrofula. Quinine is particularly recommended by Mackenzie, and a combination of quinine with sulphate of iron (F. 16, &c.) by Mr. Walton. Pure air is essential. *Secondly.* Various applications are recommended to relieve the distressing intolerance of light, such as cold lotions applied to the outside of the eye, and to the forehead and temples; or water to which a little vinegar or spirit, or nitric æther, has been added; or the white of egg curdled with alum, or warm poultices, or dec. papav. vel anthemid., or exposing the eye to the vapour of warm water, or to the vapour of laudanum or sp. camph., which may be put into a teacup and be held in warm water; but belladonna, F. 149, applied round the eye is the most efficacious, and small doses of extract of conium internally. *Both* eyes should be protected by a shade. *Thirdly*, in the advanced stage of the disease, benefit may be derived from dropping in a few drops of dilute vin. opii or lotion of nitrate of silver (gr. i. ad ℥i.) once a day, and especially from the application of dilute citrine ointment to the edges of the lids at bedtime.

VII. Granular Conjunctiva signifies a thick, rough, fleshy state of that membrane (especially of that part of it which lines the eyelids), and is a frequent consequence of severe and long-continued ophthalmia, or probably of treatment by applications of too irritating a kind. It causes great pain and disturbance to the motions of the eye, and, if it continues, will render the cornea opaque by its friction.

Treatment.—The directions generally given are, that the thickened part should be scarified; that, after one or two days, it should be touched with lunar caustic or sulphate of copper, that the scarification and caustic should be repeated alternately at intervals of two or three days, and that, if these measures prove fruitless, the thinnest possible layer of the granular surface should be shaved off with a fine knife or scissors. But it is a sounder plan of treatment to use counter-irritation on the outside of the eyelids, and improvement of the general health by tonics and change of air; and to discard any local application that causes pain or uneasiness, especially if this state of conjunctiva follows an attack of inflammation that has been freely treated by caustic. When the malady is idiopathic, the system is, according to Mr. Walton, much below par, and requires tonics. It is *the* complaint of the poor Irish.

VIII. PTERYGIUM is a peculiar alteration of the conjunctiva,—a triangular portion of which, with the apex towards the cornea, becomes thickened, elevated, red, and fleshy. It may spread over the cornea and obstruct vision; but it does not cause much inconvenience besides, and is not essentially an inflammatory affection, although it sometimes follows protracted ophthalmia. It is most common in warm climates, such as Calabria: the examples seen in London are chiefly in persons who have returned from the West Indies. The author would suggest the affinity of this growth to the *cheloid* tumour of the skin.

Treatment.—If the disease is increasing, excision should be performed. The growth should be seized close to the cornea with tenaculum forceps, should be cut quite across, and be dissected off, towards the internal canthus. But yet, as Mr. Walton directs, that portion which covers the cornea should not be meddled with, because after the operation that will probably waste; neither should the semilunar fold and caruncle be extirpated.

IX. TUMOURS, such as warts, polypi, fibro-plastic, and even enchondromatous growths, may spring from any part of the conjunctiva, whether near the cornea or not. Early excision by curved scissors is the remedy.

SECTION VI.—DISEASES OF THE CORNEA.

I. ACUTE INFLAMMATION OF THE CORNEA, or *acute keratinitis*, is occasionally a consequence of neglected injury. The part becomes red and opaque, the sclerotic around highly vascular; and ulceration of the cornea, or suppuration between its layers, or abscess of the anterior chamber, may ensue. A few leeches to the temples may be required if the attack be very acute, and fomentations generally afford relief. Small doses of mercury, discontinued or suspended should the gums become tender, will check the progress of the inflammation, but this should be given along with quinine and ammonia, and the diet should be liberal. The treatment of the diseases of this extra-vascular tissue is essentially tonic. Stimulating applications are prejudicial. Turpentine in the dose of one drachm three times a day, in an emulsion with carbonate of soda and mucilage (F. 74), has been recommended.

II. SCROFULOUS KERATINITIS, or CORNEITIS, most frequently occurs between the ages of six and eighteen.

According to Mr. Jonathan Hutchinson, it is, in the great majority of instances, the result of hereditary syphilis, and is constantly seen in connection with that peculiar stunted and abortive growth of the teeth, which he has traced as a result of syphilitic stomatitis in infancy.

Symptoms.—The cornea opaque, rough, and red, and unusually prominent; the surrounding sclerotic also red; pain and intolerance of light are generally trivial; there is some tendency to inflammation of the iris and retina; the pulse is frequent, and the skin dry.

Treatment.—For the acute, purgatives and fomentations. For the chronic, quinine, iron, and cod-liver oil, perseveringly administered; blisters repeatedly applied to the temples and behind the ears; iodide of

potassium and the general treatment directed for scrofula. The vin. opii, and ung. hydr. nit. ox. to the eyelids, are almost the only local applications admissible.

III. OPACITY of the cornea may be divided into two kinds. 1st. The opacity which results from the ADHESIVE INFLAMMATION, and effusion of fibrine between its layers, or between it and the conjunctiva, which is a very common consequence of inflammation of the cornea, and of scrofulous ulcers during their healing stage; and 2ndly, the opacity, or *leucoma*, which is produced by a loss of substance and its resulting cicatrix,—that which follows a pustule of the small-pox, for example. The former kind is in most cases curable; the latter generally not so.

When an opacity of the former kind is slight and diffused, it is called *nebula;* when denser and of a firmer aspect, *albugo*. Sometimes the lymph forming an albugo becomes vascular, and one or more vessels run to it from the circumference of the eye, and the cornea becomes red and fleshy: this state of things is called *pannus*.

Treatment.—1. All sorts of irritation about the eye or lids, and most especially inverted lids, or inverted hairs, or granular conjunctiva, must be removed, and any existing degree of inflammation be counteracted by proper measures. Then, 2, absorption of the lymph may be promoted by counter-irritants, such as blisters or tartar-emetic ointment behind the ears; by measures calculated to improve the health; and by the application of stimulants to the eye. The ordinary applications are, caustic lotion (gr. i. ad ℥j.), or hydr. bichlor. gr. i.—ad aq. ℥j.; vin. opii; or, ung. hydr. nit. ox. Whichever is selected should not excite long-continued pain or active inflammation. Gooch used to cure opacity of the cornea, even of long standing, and, in fact, other forms of chronic inflammation of the eye, by the administration of corrosive sublimate, in doses that would now be considered hazardous. He gave gr. ¼ twice a day; and in a few days' time increased the dose to gr. ½, and then to gr. i. It caused feverishness, purging, slight sweating, and headache.

IV. LEUCOMA signifies an opaque cicatrix of the cornea. If recent, it may become much better spontaneously, or may be partially removed by the measures just indicated. If of long standing, it is irremediable, and sometimes becomes the seat of calcareous degeneration, a small particle of earthy matter being found in it, which may require removal because of its friction against the eyelids. Should *both* eyes be affected with leucoma, and should the opacity be exactly in front of the pupil, and so large that vision is lost, it will be right, provided that dilatation of the pupils by atropine does not improve sight, to make an artificial opening in the iris opposite some part of the cornea that is transparent.

Mr. Bowman has described a case of *warty opacity*, caused by the development of vascular papillæ, covered with hypertrophied epithelium; and relieved by shaving off the morbid growth to the level of the healthy cornea.*

* Op. cit., pp. 39, 122.

Superficial Opacities—"There are some varieties," says Mr. Bowman, "which appear to be on or near the very surface of the cornea, and which it is probable may occupy the anterior elastic lamina. The very opaque chalky-looking films which often follow the application of quicklime or new mortar to the eye, seem to be of this kind, and so, also, do those which have been supposed by some to be stainings of the surface of the corneal tissue by a deposit of the lead lotion in common use. Occasionally we have a superficial excoriation of the cornea—one can hardly call it an ulcer—which the epithelium limits with abrupt edges, thus favouring the accumulation, on the depressed surface, of the frothy mucus or sud which the movements of the lid furnish.

"The opacity thus produced is often very opaque, and unless you were aware of its cause, might seem more serious than it really is. A lens, or the point of a needle, will inform you of its real nature.

"There is another form of opacity, which I believe to have its seat in the anterior elastic lamina, although it is vain to endeavour to prove it, except by a section of the parts. It has a silvery lustre, and a very fine texture of interweaving striæ, and it creeps very gradually from near the border, over the surface of the cornea, towards the centre. The epithelial surface retains its smoothness and lustre, and the opacity does not appear to have much depth. Other varieties of opacity, very chronic in their course, and evidently not inflammatory, are liable to form, as I believe, in the same tissue. They may be of a brown tint, with an indefinite margin, and may affect both corneæ at the same time."

Superficial opacity, caused by a thin film of earthy matter, has been successfully removed by operation by Mr. Bowman,* Mr. Dixon, and Mr. Haynes Walton.

If the *acetate of lead* is used as a collyrium when there is any abrasion of the conjunctiva or cornea, a white precipitate is formed, which is liable to become fixed in the cicatrix as a dense white spot. The film may, however, sometimes be removed by a needle. The *nitrate of silver*, if applied too long, is apt to turn the conjunctiva of a deep olive hue.

V. ONYX signifies a suppuration between the layers of the cornea, and is an occasional result of acute ophthalmia, especially of the catarrho-rheumatic, but more commonly follows slight injuries. It is liable to extend rapidly, and to destroy the whole or great part of the cornea by sloughing. It indicates a debilitated constitution, and must be treated with tonics and stimulants, *e. g.* quinine and ammonia. If there be much tension of the eyeball, the aqueous humour should be evacuated, care being taken that the puncture is made in a sound part of the cornea.

VI. ULCERS of the cornea may be the results of the *phlyctenulæ* of scrofulous ophthalmia, or they may arise from mechanical injury, or from any form of conjunctival inflammation. They may likewise com-

* Op. cit., pp. 37, 117.

mence as mere abrasions, or as little nebulous spots, independently of any other affection. When a consequence of the scrofulous phlyctenula, they are generally deep, and tend to perforate the cornea, and leave an opaque cicatrix; when arising from other causes, they are often superficial, and heal with a semi-transparent cicatrix, which gradually becomes clear.

"These ulcers may," as Mr. Tyrrell observes, "exist in three states. *First*, that which we may term healthy, when the surface and circumference exhibit a degree of haziness or opacity of a whitish or grey aspect, which is owing to the effusion of adhesive matter on the surface, and in the surrounding texture, which is essential to the healing of the part." In this state the case merely requires to be watched, to prevent injurious increase of action.

"*Secondly*, an ulcer may be inflamed, when its hazy circumference will be observed to be highly vascular. Leeches and counter-irritation, with soothing applications, are the remedies. But an ulcer is not necessarily inflamed because it has red vessels going to it: these bring materials necessary for its repair, and are not morbid.

"*Thirdly*, an ulcer may be indolent, clear, and transparent, looking as if a little bit had been cut out of the cornea; without any vascularity or effusion of lymph. This state requires slightly-stimulating applications."

Again, ulcers may form on a surface that is already rendered opaque and nebulous by scrofulous inflammation. However, in any case, counter-irritation, and measures to improve the health, together with weak caustic lotion or vin. opii used twice a day, are the chief remedies. The surgeon should remember the tendency of the cornea to slough from insufficient and non-azotized food, as proved by the experiments of Majendie. The pupil should be dilated with belladonna, if the ulcer is near the centre of the cornea.

When an ulcer is very irritable, keeping up constant pain and intolerance of light, in spite of soothing applications, the best plan is to touch its surface with a finely-pointed pencil of nitrate of silver, so as to produce an insensible film on the surface: this is to be repeated at intervals of three or four days.

VII. STAPHYLOMA is a term employed to signify any protrusion on the anterior surface of the eye. 1. *Staphyloma iridis* signifies a protrusion of the iris, which occurs when the cornea is perforated by ulcers or wounds. The term *myocephalon* is applied to the protrusion of a very small piece of the iris through an ulcerated opening in the cornea. For the treatment see p. 395.

* This figure exhibits the healing stage of an ulcer of the cornea. It is copied by Mr. W. Bagg from a drawing for which the author has to thank Mr. Partridge.

2. *Staphyloma of the cornea* is said to exist when a portion or the whole of the cornea, whose texture has been disorganized by injury or disease, has perished; and the cicatrix with which the iris has become covered, bulges before the pressure of the humours of the eye, and forms an opaque white prominence. If *partial*, it is usual to recommend that the nitrate of silver or butter of antimony be applied to the apex of the staphyloma, so that the inflammation excited may thicken the cornea, and enable it to resist further protrusion; the caustic to be well washed off with milk before the lids are closed. But besides sympathetically affecting the other eye, it is seldom that the use either of the nitrate of silver or butter of antimony checks the increase of staphyloma, and sooner or later the eye collapses from the necessarily extensive use of the knife. Therefore, when the staphyloma is still limited, Mr. H. Walton shaves it off; by which means the cut part frequently cicatrizes, and no further protrusion is effected. This treatment is applicable to small staphylomata, and especially those that rise suddenly, and have a small, well-defined base.

VIII. Hernia Corneæ.—When the cornea is nearly perforated by an ulcer, a thin transparent vesicle is apt to protrude from the aperture, consisting of a thin lamella of the cornea; the posterior elastic membrane. The best plan is to keep the eyelids closed for a few days. Cicatrization to the edges of the cornea soon ensues.

IX. Conical Cornea.—In this curious affection the cornea retains its transparency, but assumes, more or less, a conical form, the apex being generally central. As it increases it causes almost total deprivation of vision, which, however, can be partially remedied by looking through a minute aperture in a piece of blackened wood, and sometimes by using concave glasses; sometimes by a combination of the concave glasses with the wood having the hole in it, or a perforated diaphragm set in a spectacle-frame. Mr. Bowman * recommends that the pupil should be limited in size and altered in position. He performs an "iriddesis" downwards, and in a week or ten days again operates upwards. The pupil thus assumes the form of a vertical slit, like the pupil of a cat. The results of his operations have been satisfactory. See Artificial Pupil.

X. Arcus Senilis is the name given to a circumferential opacity of the cornea, which has been shown by Mr. Canton to depend on fatty degeneration. As its name implies, it is most generally met with in the aged, and affects each eye symmetrically. When existing in one

* Ophthalmic Hosp. Reports, Oct. 1859.

eye only, it is generally connected with some previous injury or disease which has spoiled the corneal tissue. Mr. Canton has pointed out that the arcus, when met with in early life, as at fifty, forty, thirty, or earlier, is often associated with fatty degeneration of the heart.*

SECTION VII.—DISEASES OF THE SCLEROTIC.

I. Acute Inflammation of the Sclerotic is commonly called Rheumatic Ophthalmia; because the structure affected is similar to that which is commonly said to be attacked by rheumatism. But sclerotitis is, properly speaking, an inflammation of the sclerotic, and in some measure also of the cornea, iris, and other proper structures of the eyeball; and it ought not to be called rheumatic, unless there are pains in the joints, acid perspiration, or other evidences of the rheumatic diathesis.

Symptoms.—It is known by redness of the sclerotic,—dimness of sight, sometimes great intolerance of light, sometimes not—severe stinging pain of the eye, and aching of the bones around, which is greatly aggravated at night,—and fever. It may be caused by cold; and sometimes is a sequel of gonorrhœa. It may lead to opacity of the cornea, or to iritis.

Diagnosis.—This form of ophthalmia may be distinguished from inflammation of the conjunctiva, 1st, by the character of the pain, which is a severe aching, principally felt in the eyebrow, temple, and cheek, and is greatly aggravated every evening; being excessively severe during the night, but remitting towards morning. Whereas, in conjunctivitis, the pain is of a scalding nature, and accompanied with a sensation as if sand was in the eye. 2ndly, by the character of the redness, which is deep-seated and of a pale pink; and by the vessels running in straight lines from the circumference of the eye towards the cornea; whereas in conjunctivitis the redness is scarlet and superficial, and more vivid; the vessels are tortuous, and freely anastomose, and can be moved about with the finger.

Treatment.—In severe cases, it is commonly said to be necessary to bleed generally or locally; at all events, to purge, and administer mercury with opium till the gums begin to suffer. But Mr. Taylor says, that he has seen severe cases treated by bleeding, leeching, and mercury, and that all have been made worse. The plan which he has found rather successful, is to give bark and iodide of potassium, with mercury in small doses or with tincture of colchicum at bed-time; and he says that blisters to the temple or eyebrow are sometimes useful. The pain may be relieved by friction of the forehead every afternoon, with extract of belladonna dissolved in warm laudanum (℥j. ad ℥j.), or F. 149, —warm pediluvia or warm bath,—and Dover's powder at bedtime. When decidedly intermittent, and out of all proportion to vascularity, it may be relieved by five grains of quinine every four hours till the

* Lancet, Jan. 11, 1851.

ears ring. Dry warmth, by means of muslin bags filled with camomile flowers, and heated on a hot plate, is a very soothing application.

II. CATARRHO-RHEUMATIC OPHTHALMIA is a combination of inflammation of the sclerotic with that of the conjunctiva. The symptoms of conjunctivitis, that is to say, roughness and sense of dust in the eye, muco-purulent discharge and superficial scarlet redness,—are combined with the deeper-seated, straight-lined redness, and with the zone around the cornea, and fits of nocturnal aching that characterize inflammation of the sclerotic. This disease generally occurs in broken-down constitutions, and is very apt to lead to onyx, and to ulceration of the cornea, and suppuration in the anterior chamber.

Treatment.—Warm opiate collyria, F. 142, weak citrine ointment, and the other topical applications for conjunctival inflammation, must be used in addition to the remedies prescribed for inflammation of the sclerotic.

III. TUMOURS OF THE SCLEROTIC require caution in meddling with them, lest the cavity of the eye be opened.

SECTION VIII.—AFFECTIONS OF THE ANTERIOR CHAMBER.

1. The term AQUO-CAPSULITIS has been applied to signify inflammation of the membrane of the aqueous humour. But it will be highly satisfactory to know, that as there is no such membrane, so there can be no such disease; and that the appearances commonly considered to denote this disease,—namely, a mottled opacity of the posterior layers of the cornea—really denote inflammation of the posterior layers of the cornea.*

II. ENTOZOA.—The *Cysticercus Cellulosæ* has on several occasions been found within the anterior chamber. In most of the recorded cases the patient has been the subject of one or more acute attacks of inflammation of the eye leading to opacity of the cornea. On examination a globular vesicle was discerned floating in the anterior chamber. It requires to be extracted by incision.†

SECTION IX.—DISEASES OF THE IRIS.

I. INFLAMMATION OF THE IRIS, or IRITIS.—The iris is exceedingly liable to inflammation, which generally involves also the sclerotic, the anterior capsule of the lens, and in fact most of the deeper structures in the eyeball. Dr. Jacob has well remarked, that "The use of the term iritis has the effect of directing the practitioner's attention to the iris, which bears a great deal of inflammation without destruction to the organ, and of withdrawing it from the retina, which bears very little, without permanent injury to vision."

* See a Clinical Lecture by H. Haynes Walton, on the Non-existence of Aquo-Capsulitis, Med. Times, 5th May, 1855.

† See Mackenzie, Med. Chir. Trans. vol. xxxii.; Canton, Surgical Observations, Lond. 1853; Haynes Walton, Operative Ophthalmic Surgery, p. 502.

Symptoms.—In the first stage, the fibrous texture of the iris is indistinct, appearing confused, and it loses its colour; if dark, it becomes reddish; if blue, it becomes greenish. The pupil, also, loses its mobility, is contracted and irregular. In the next stage, lymph begins to be effused; sometimes in the form of a thin layer, causing the surface to appear rusty and villous,—sometimes in small nodules; sometimes the pupil is filled with a film of it, sometimes, but very rarely, it is poured out in such abundance as to fill the whole cavity of the aqueous humour. The eye displays that kind of redness which arises from vascularity of the sclerotic; that is to say, a pink redness, with vessels running in a straight line from the circumference of the eye, and terminating in a vascular zone around the cornea; but in very acute cases the entire conjunctiva becomes injected likewise. Sometimes the cornea is slightly hazy. The patient complains of intolerance of light and dimness of vision, and of more or less burning, stinging pain in the eye; but besides this, there is also a severe neuralgic aching of the brow and parts around the orbit, coming on in nocturnal paroxsyms.

Causes.—Iritis, as we explained in the first section, may be caused by injuries, or by over-exertion of the eye; but it more frequently depends on constitutional taint, syphilis, or gout.

Prognosis.—Favourable, if the disease is recent, although the impairment of vision may be considerable; but doubtful, if it be of very long duration, if there be much deep-seated pain, and especially if there be effusion of lymph behind the iris.

Varieties.—Iritis may vary in the degree of acute inflammation which attends it; being active and rapid, attended with bright redness, great pain, and fever, if it occurs in a robust plethoric subject; but in other cases, slow and insidious. It is also divided into several species, according to the nature of the cause producing it. Thus:—

1. The *traumatic iritis* is that which arises from penetrating wounds of the eye.

2. *Syphilitic iritis.*—This is the most frequent variety. It is distinguished by the effusion of lymph on both surfaces of the iris, and in little nodules of a reddish or dirty-brown colour, which cause the pupil to become irregular. There is great pain at night, and but little by day, and secondary venereal affections of the throat or skin are usually present at the same time, or have preceded it. It may occur to infants who are affected with constitutional syphilis.

* A drawing representing the nodules of lymph effused in syphilitic iritis.

3. The *rheumatic* iritis arises under the conditions that cause the development of rheumatism in other organs. It differs from the syphilitic variety in the fact that there is less tendency to the deposit of lymph on the iris, and in the anterior chamber. The iris becomes dull and discoloured, *without showing nodules of lymph*, yet the pupil is more likely to become irregular and adherent; and the adhesion is, too, for the most part more general. Occasionally a little ring of fibrinous matter is deposited on the capsule of the lens, just within the circle of the adherent pupil. It is from such deposits, the accumulated effects of many attacks of inflammation, that the eye becomes destroyed. The surface of the eyeball is more inflamed, and frequently of a purplish-red colour, consequently there is not the definite zone of sclerotic redness that is usually so clearly defined in syphilitic iritis. The cornea, especially the posterior elastic lamina, is prone to become more or less opaque in patches, remains of which opacity may be permanent. But there is no greater characteristic of the disease than its tendency to return, insomuch that a person may have an attack once or twice a year, or at longer intervals, during a long life, and this, even after the pupil has been closed by plastic material. It may be well to state that a white ring around the cornea is present in all inflammations of the surface of the eye in which the cornea remains clear and vascular.

4. *Scrofulous iritis.*—This term may be used to signify either idiopathic iritis occurring in a scrofulous habit, and generally combined with corneitis; or else a deposit of cachectic lymph on the iris, which leads to scrofulous suppuration of the eyeball, or atrophy.

Treatment.—The indications are, 1, to subdue inflammation; 2, to arrest the effusion of lymph, and cause absorption of what is already effused; 3, to preserve the pupil entire; 4, to allay pain.

1. If the patient be strong, and the disease acute, with full strong pulse, and much fever, bleeding from the arm, or cupping from the temple may be requisite. The bowels must be well cleared, the antiphlogistic regimen generally be observed, without bringing the patient into a state of debility, and blisters be applied after the most acute stage has subsided.

2. To fulfil the second indication, the principal remedy is mercury; and the ordinary plan of administering it is to give gr. i.—ii. of calomel with gr. $\frac{1}{4}$—$\frac{1}{2}$ of opium at intervals of six or eight hours. But a most salutary change has come over the practice of surgeons in the administration of mercury, as well as in the use of bloodletting. It is now some years since, in attending a case with Mr. Walton, that the writer learned from him, with much satisfaction, the efficacy of small doses in iritis; such as two or three grains of hyd. c. cretâ, combined with hyoscyamus or conium, and given twice, thrice, or perhaps four times in the twenty-four hours, and the doctrine that the curative effect of mercury is almost always to be produced, short of salivation, which may well be termed one of the poisonous effects. If the remedy be thus gently administered, the dose being lessened so soon as the mouth begins

to be tender, the lymph will generally be found to break up and gradually disappear, leaving the pupil clear. In debilitated or scrofulous subjects, and in tedious cases, tonics, such as bark, cod-liver oil, or iodide of potassium may be given with the mercury. Turpentine in drachm doses, F. 74, has been recommended in iritis instead of mercury; but its efficacy admits of doubt.

3. The pupil should be kept well dilated by means of a filtered solution of one scruple of extract of belladonna in an ounce of distilled water. But the most elegant way is to drop into the eye a solution of the *sulphate of atropine* (gr. i. ad. ℥i. aquæ distill.). Stramonium and hyoscyamus have the same effect, but in a much less degree.

4. The pain must be relieved by nightly doses of opium, and the application of poppy fomentation to the eye, and the rubbing in of the unguentum opii to the temple.

In the *rheumatic iritis* the secretions of the liver and bowels should first be well cleared out by calomel with warm aperients; then the hyd. c. creta in very small doses twice daily, with colchicum, alkalies, and purgatives, and counter-irritants, are the best remedies. Pediluvia containing mustard should be used every night. The same plan of treatment will serve for the *gouty* iritis, if such a disease should be met with.

II. SYNECHIA POSTERIOR, adhesion of the uvea to the capsule of the lens; SYNECHIA ANTERIOR, adhesion of the iris to the cornea; and ATRESIA IRIDIS, or closure of the pupil,—three consequences of organization of lymph from protracted iritis,—may be partially removed by mercury, if recent, but are irremediable, except by operation, if of long standing. But belladonna should always be applied; because if a very small portion of the pupil is by chance unadherent, it may be dilated, so as to afford a very useful degree of vision.

III. MYOSIS—a preternaturally-contracted pupil—is sometimes met with in persons accustomed to look at minute objects, and is attended with great obscurity of vision, especially in a feeble light, because the iris is unable to dilate. To give repose to the eyes, and attend to the health, are the only available indications of treatment: Mackenzie says that belladonna is hurtful.

IV. MYDRIASIS signifies a preternatural dilatation of the pupil, which does not contract on exposure to light. This state, as is well known, is readily produced by belladonna and many other narcotico-acrid poisons; it is caused also by any injury of the brain affecting the *tubercula quadrigemina*, as in apoplexy and compression of the brain; and is often an attendant of confirmed amaurosis. But sometimes it seems to depend simply on a derangement of the nerves supplying the iris, without diminution of the sensibility of the retina; and this form of it may also be attended with ptosis; as a further evidence of paralysis of the third nerve. Sometimes it depends on gastric irritation and general debility, and is lessened as the health improves. If the retina is sound, which will be known by the perception of light, and by vision being improved by looking through a small round aperture in a

piece of blackened card, concave glasses are often of service. One case is recorded which was said to be cured by ergot of rye, in scruple doses four times a day.* Generally speaking, in uncomplicated cases, the prognosis is good if a tonic plan of treatment be adopted. Mr. R. Taylor has seen good results follow a succession of blisters to the temple or brow, and the application of stimulating vapour—as of ammonia—to the eye. He also believes that nux vomica is of service.

V. CYSTS filled with watery fluid, and growing from some part of the iris, may be mistaken for cysticercus, or dislocated lens; the chief distinction being that they have a fixed attachment. A cyst may be congenital, or may grow after some injury. If allowed to remain and increase, the whole eyeball becomes disorganized. The usual treatment recommended is, to incise the cornea, draw out the cyst, and cut it off. But this is a most severe operation, and one likely to be followed by the loss of vision; whereas Mr. Walton gives cases which show that if the cyst be punctured freely with an iris knife, it will collapse and give no further trouble. The operation may, however, require to be repeated.

VI. ARTIFICIAL PUPIL.—By this is meant an alteration in the shape or position of the pupil, or a new aperture in the iris, effected by surgical operation, for the purpose of allowing the rays of light to reach the retina.

The *cases* in which such an operation may be expedient, are, 1, partial *opacity of the cornea*; 2, complete or partial *closure of the pupil by lymph*; 3, closure of the pupil from prolapse of the iris, or adhesion of it to the cornea, in consequence of ulceration or of wound of the cornea, which, in this case, is more or less opaque; 4, closure of the pupil, after the crystalline lens has been extracted or absorbed.

Respecting the various *forms of operation* which have been proposed for these and for the other combinations of circumstances that may be met with, we must content ourselves with detailing such general principles as every surgeon ought to be acquainted with; referring those who wish for fuller information to the works of Bowman, Wilde of Dublin, Mackenzie, Guthrie, Wharton Jones, Tyrrell, and Walton. Such particulars as we give are gathered chiefly from the "Operative Ophthalmic Surgery" of the last-named gentleman.

1. There is the operation by *incision* (*coretomia*), which is especially available when the pupil is closed, after the removal of the lens, and when the cornea is clear, and the iris tolerably healthy in structure, so that it is capable of retracting and forming a roundish pupillary aperture, after incision. The instrument employed is the *iris knife*, a lancet-shaped knife of various dimensions, according to the size of the aperture required. This is carried through the cornea, near its margin, across the anterior chamber, and thrust up to its shoulder into the iris.

* L'Experience, Sept. 1839.

2. The operation of *incision with extension* was proposed by Mr. Walton for cases in which, owing to loss of contractility in the iris, a sufficiently large aperture could not be made by simple incision. The iris is divided by incision, and then, by means of a fine blunt hook, the outer lip of the incision is drawn outwards till a sufficient opening is made.

3. A third operation, similar in principle to the last, is effected by introducing a very fine pair of scissors, through a wound in the margin of the cornea; thrusting one blade through the iris, and making first one cut, then a second, meeting at an acute angle like the letter V.

4. The operation of *excision* (*corectomia*) consists in incising the cornea, close to the margin, drawing out the iris by a hook or forceps (if it does not protrude of itself), and cutting out a small portion of it. This is applicable to cases of opacity of the cornea, with the iris and lens healthy; or to closure of the pupil from lymph, with adhesion to the centre of the capsule, without opacity of the lens or of the rest of the capsule; for it is now established that the centre of the capsule may be opaque from lymphy deposit after iritis, and the lens and rest of the capsule remain transparent.

5. Another operation adaptable to cases of closure, complete or partial, of the pupil, the lens being healthy, consists in puncturing the cornea, introducing the very fine canula forceps, seizing the iris close to the pupil, and tearing away a portion of it; or else introducing a hook, seizing the edge of the pupil, and tearing a thin strip outwards.

6. The operation of *separation* (*coredialysis*), which consists in tearing away a portion of the circumference of the iris, is resorted to when there is central opacity of the cornea, with a portion of the circumference clear; the pupil being also closed from prolapse or adhesion to the cornea.

7. The operation of *Iridodesis*, devised by Mr. Critchett.* It is thus performed: a small opening is made into the anterior chamber close to the margin of the cornea; the iris is seized with the canula forceps near its ciliary margin, and drawn out until the pupil is sufficiently displaced, and the piece thus drawn out is secured and strangulated in a small loop of floss silk, previously slipped over the forceps, and drawn tight by an assistant. This operation is particularly applicable in cases of central opacity of the cornea.

The best position for the pupil is as nearly central as possible: if it cannot be made central, it is better, according to Mr. Walton, at the inferior margin of the iris.

But before resorting to any of these operations, it must be ascertained, 1st, that the adhesions of the iris cannot be removed by mercury or belladonna; or opacity of the cornea by external applications, aided by *time*, which, if the health be kept in good order, does much towards restoring every impaired organ to its normal condition; 2ndly, that the retina is perfectly sound; 3rdly, that all tendency to inflamma-

* Ophthalmic Hosp. Reports, vol. i., p. 220.

tion (syphilitic or otherwise) has ceased. It is not advisable to operate if one eye be quite sound; and supposing one eye to be irrecoverably lost, it is not advisable to form an artificial pupil in the other, provided the patient find his way about with it. Moreover, the new pupil should be made large, because it will always contract somewhat afterwards.

SECTION X.—INFLAMMATION OF THE CAPSULE OF THE CRYSTALLINE LENS.

This is a very rare affection, and always chronic. Vision is confused,—objects looking as if they were seen through a fine gauze. On examining the eye with a strong lens in a good light, the pupil being well dilated with atropine, a number of minute red vessels are seen in the pupil. If the anterior capsule be affected, the vessels form a circular wreath of vascular arches with the centre clear; if it be the posterior capsule, they are central and arborescent. The iris is always slightly discoloured and sluggish.

Treatment.—Local bleeding, if necessary; mercury, counter-irritation, change of air, and alteratives.

SECTION XI.—CATARACT.

DEFINITION.—An opacity of the crystalline lens or of its capsule, or of both.

SYMPTOMS.—Before examining any patient with suspected cataract, the pupil should be dilated with atropine, F. 198, and then, if there be capsular cataract, there will be seen behind the pupil an opaque body of a gray dead-white; if lenticular cataract, of a bluish-white, or amber-colour. The patient usually gives as his history, that his vision has become gradually impaired; that objects appear of irregular outline, or multiplied, or as if surrounded with a mist, or as if a cloud was interposed between them and the eye. If lenticular cataract alone be present, he will say that the sight is better in the evening, or in a subdued light, or when the back is turned to the window; or perhaps after the application of belladonna or atropine,—obviously because the pupil, being dilated under those circumstances, permits more light to pass through that part of the lens which is as yet transparent, or which, though opaque, is thinner, and therefore affords less obstruction to light than the centre. In the most confirmed cases, the patient is yet able to distinguish day from night.

There is also the *catoptric test*,—that is, the mode of examining the eye by the reflection of light, which was proposed by M. Sanson. When a lighted taper is moved before the eye of a healthy person, three images of it may be observed. 1st. An erect image, that moves upwards when the candle is moved upwards, and that is produced by reflection from the surface of the cornea. 2ndly. Another erect image, produced by reflection from the anterior surface of the crystalline lens,

which also moves upwards when the candle is moved upwards; and 3rdly. A very small inverted image, that is reflected from the posterior surface of the crystalline lens, and that moves downwards when the candle is raised upwards. To render this most distinct, the pupil should be dilated, and the examination be made in a dark room. Now, in lenticular cataract, this inverted image is from the first rendered indistinct, and soon abolished; and the deep erect one is soon afterwards abolished also. In capsular cataract, from the first, only the front erect image, that, namely, produced by reflection from the cornea, is visible. But the disease must be advanced, and the observer experienced, if this test is to avail; and the ophthalmoscope gives the earliest means of detecting opacity of the posterior part of the lens.

DIAGNOSIS will be spoken of under Amaurosis and Glaucoma.

CAUSES.—Cataract, especially capsular, is sometimes attributable to inflammation, and may be caused in a short space of time by wounds or other injuries of the lens and capsule, or of the eye in general. But the ordinary cataract of old age seems to be a mere effect of impaired nutrition.

1. *Hard Cataract.*—This form is met with in elderly people only. It is caused, according to Mr. Walton, by grayness or opacity appearing in an already discoloured lens; and the greater the coloration of the lens, the less will be the amount of grayness required to obstruct vision. After thirty, the lens naturally acquires a yellow colour, and the hue becomes deeper, till it is like a piece of amber. The amber colour, therefore, the characteristic hue of cataract in aged persons, is not the effect of disease. Sometimes the colour is as deep as that of dark mahogany: and Mr. Walton has brought before the Royal Medical and Chirurgical Society the particulars of a case in which the cataract was so black that it could not be detected till the eye was examined with the ophthalmoscope, or the concentrated light of a powerful lens.

According to Mr. R. Taylor* the change in such cataractous lenses is twofold. The nucleus becomes hard and dry, to a degree far exceeding what is ever seen in the healthy lens; while the superficial layers are softened, frequently to the state of a semi-fluid pulp. The nuclear lens-fibres are hard, atrophied, and brittle, and are rendered more or less opaque by fine molecular deposit, as well as by little cracks and fissures. Those of the superficies are softened, and more or less disintegrated; they, also, are dotted over with fine molecular matter, which is also found floating free in masses, and filling up, and rendering opaque, many of the superficial lens-cells. This molecular matter is probably the result of the coagulation of the albuminous blastema by which the whole of the lens textures are pervaded.

The opacity generally commences in the superficial layers of the lens, for the most part in the form of streaks or radii, converging towards the centre, or, more correctly speaking, following the course of the natural division of the lens. Less frequently it commences in the nucleus, in the form of a cloudy opacity. When the disease is of long

* Pathological Transactions, vol. vii.

standing, the surface of the cataract frequently assumes a uniform milk or cream-white colour.

2. *Soft Cataract.*—While hard cataract is seen only in persons above thirty-five years of age, soft cataract may occur at any period of life. It appears to be due to disintegration affecting the whole substance of the lens, similar to that which affects the surface alone in hard cataract. The colour in infancy is bluish white, like milk and water; later in life there is generally less of the blue tint. The surface frequently presents an appearance like that of fractured spermaceti; or it may be traversed by radii and streaks, which glisten like a piece of tendon. In this variety vision is generally more imperfect than in the hard kind. The iris is frequently pressed upon by soft cataract; but this may also occur in hard cataract when the surface of the lens is much degenerated. This phenomenon is probably due, in the majority of instances, to the swelling of the diseased lens from the imbibition of moisture; but in other instances, the opinion of Mr. Walton is doubtless correct, that it is caused by unnatural vascularity in the deep-seated textures of the eyeball.

3. *Congenital Cataract* must, therefore, always be soft. In this variety vision is generally more imperfect than in the hard kind.

4. *Capsular Cataract.*—In this variety the opacity may be general, or may commence partially. It is almost invariably of a dead or chalky whiteness, scarcely ever shining, and always showing the same opacity in whatever position it may be viewed. It is not unfrequently the result of a slow inflammation, which may be accompanied with pain in the eye. It may be produced also by inflammation extending from the iris. Opacity of the *anterior* portion may be seen immediately behind the iris. That of the *posterior* appears at some little distance behind the pupil, and presents a concave striated surface, of a dull-yellowish appearance.

5. *Capsulo-lenticular* cataract is very common,—in fact, entire opacity of the capsule is always followed by opacity of the lens.

Treatment.—The cataract must be removed by operation. No other treatment is of any avail to get rid of the disease. It is, however, a general rule not to operate till the cataract is *mature*—that is, not whilst the degree of vision is sufficient for ordinary purposes; more particularly if the patient is very old and feeble, or if one eye is already lost; because, under these circumstances, a failure of the operation would entail utter blindness. Therefore the patient should assist his vision by using F. 198, night and morning, so as to dilate the pupil, and defer the operation till, despite of that aid, his blindness is complete.

Prognosis.—This will be favourable if the patient is in good health and of temperate habits; if the iris moves freely, and if the retina seems perfectly sensible to light. On the other hand, it will be doubtful if there are signs of vascular disturbance in the eye; if the iris is motionless or altered in colour; or if the cataract is complicated with amaurosis, softness of the eyeball, or glaucoma.

Preparation.—Before operating, the patient should be put into as

perfect a state of health as possible. The state of the biliary, and more especially of the urinary excretion, should be examined, and purging, exercise, and low diet be enjoined, if the habit is inflammatory. But no rude lowering measures, or violent purgation, or sudden change of diet should be resorted to indiscriminately; and many patients require a better diet, with tonics and wine.

There are three established methods of operating for cataract:—1, *extraction*; 2, *displacement* (or *couching*); and 3, *solution*, or the operation for causing absorption. Two new operations have lately been introduced, *linear* extraction, and *Schuft's* operation. These appear to be still on their trial.

I. EXTRACTION.—The object of this operation is, to make an incision through half of the circumference of the cornea, almost close to the sclerotic; to lacerate the capsule of the lens; and then to extract the cataract entire, through the pupil. Its advantage is, that it effectually removes the cataract; but it is the most difficult of all the operations for cataract, and demands, for its success, much knowledge and much practice. It is best adapted for hard cataracts in elderly people. But it should not be attempted, 1st. If the patient is very feeble, in case the wound of the cornea might not unite. 2ndly. If the anterior chamber is very small and the cornea very flat, so that a sufficiently large opening cannot be made in it. 3rdly. If the iris adheres to the cornea, or if the cataract pushes it forward against the cornea, thus rendering it impossible to incise the cornea without wounding the iris, or if the pupil is habitually contracted. 4thly. If the eye is sunken, or if the fissure of the lids is preternaturally small. 5thly. If the eyes are very unsteady, or if the patient is subject to habitual cough or asthma, or is unmanageable in consequence of idiocy. Some practitioners direct that one eye only should be operated on at a time, the other being kept as a reserve, whilst others operate on both together.

Operation.—In the precise manner of performing this, there are very many varieties. Some surgeons incise the lower, others the upper, part of the cornea; some sit before, others behind the patient; some are ambidexter, others use the right hand only. But, referring those who may wish for fuller information to the various works on ophthalmology before quoted, p. 419, we shall content ourselves with describing one method of operating, which is, we believe, most generally employed at the present day.

The instruments required are, 1, a knife having a triangular blade;

ack straight and blunt; the point sharp; the edge slanting ob-
y; the blade increasing in thickness, as well as in breadth, as it
aches the handle. The advantages of this shape are, that it fills
incision which it makes, and prevents the escape of the aqueous
ur; and that the flap of the cornea is made by one simple motion,
s, by pushing the knife onwards. That used by Mr. Walton
res from the point to the shoulder $\frac{1}{8}$th of an inch, and across the
st part $\frac{1}{16}$th of an inch, which gives a longer blade and a more
angle than that shown in the drawing. But different operators
ives of different shapes.

A *curette*; an instrument with a curved needle at one end, and
ll spoon at the other. Mr. Walton has devised a guarded curette,
ich the hook is concealed till protruded by a spring. 3. A se-
ry knife to enlarge the incision in the cornea if required. 4. A
hook.

patient may be either sitting, or lying on his back with the
properly supported, and in a good light. The operator, behind
uses his right hand for the right, and his left for the left eye. An
ant draws down the lower lid, and steadies it against the malar
without pressing on the globe. The operator, with the forefinger
e non-operating hand, raises the upper lid and locks it under the
of the orbit, just resting the point of this forefinger against the
r surface of the globe, and that of the middle finger against its
surface, so as to steady it. Then holding the knife lightly with
humb and first two fingers of the other hand, and resting his
against the side of the face, he commences by—1. Puncturing
rnea at the centre of its outer margin, half a line, or even less,
the sclerotica. 2ndly. The blade is pushed gently across, parallel
the iris, in such a way that the point shall penetrate the other
f the cornea, exactly opposite to the first puncture; and that the
shall cut an even semicircular flap of the upper half of the cornea.
when the incision is completed, which should be slowly and care-
done, the eyelids should be dropped, and all pressure be ceased.
. Having waited a few seconds, the surgeon lifts the upper lid
ently to expose the cornea, tells the patient to look towards his
o that the globe may be directed downwards; then introduces
urette, and freely lacerates the capsule of the lens. 4thly. He
very gentle pressure on the under part of the globe, and on the
eyelid, till the lens rises through the pupil and escapes. Lastly,
e should be opened after a minute or two, to see that the flap of
rnea is rightly adjusted, and that the iris is not prolapsed: if it
eyes should be exposed to a bright light, so as to make the pupil
act, and the prolapsed portion should be gently pressed upon with
oon of the curette. Then the operation is finished.

plications.—1. Sometimes, in consequence of the premature
of the aqueous humour, the iris falls forwards under the edge of
nife. If the point of the knife is completely entangled in the
is necessary to withdraw the instrument, heal the wound, and

repeat the operation afterwards. If, however, a little bit of it should get under the edge of the knife, when the section is nearly complete, an attempt should be made to extricate it by pressing on the cornea just over it with the nail; but if this does not readily succeed, the operator may push on boldly, since, if a little piece of it be cut, it will be of no great consequence. 2. If the opening of the cornea is not large enough, it must be enlarged with the secondary knife. 3. If a portion of the lens remain behind, it should be left to be absorbed—unless it has passed into the anterior chamber, and can be removed very easily indeed. 4. If the vitreous humour seem disposed to escape, the cataract should be hooked out with the hook.

After Treatment.—The patient should be put to bed, with the shoulders raised, the room darkened, and with a very soft dry linen rag over both eyes. The bowels should be kept open, and everything be avoided which is likely to provoke coughing, sneezing, or vomiting. Mr. Walton allows the usual diet, at the usual times, only in rather diminished quantity; and this plan seems preferable to that of keeping the patient exclusively on slops. If all goes on comfortably, the eyelid may be raised on the seventh day, and then if there be no prolapse of the iris, and the cornea be united, he may get up occasionally, wearing a shade, sitting in a darkened room, and walking about a little. After a fortnight the eye may be opened in a weak light, and be gradually brought into use. But, inasmuch as it remains weak and irritable, the patient must take the greatest care to avoid exposure to cold, excess in diet, over-exertion of the eye, or exposure of it to too strong a light. Gray spectacles are the best protectors against too glaring a light. The patient will require convex spectacles for exact vision, but they must be used very sparingly for some weeks. He should have two pairs, one with a short focus for near objects, and another of long focus for distant objects.

The inflammation which may come on after the operation may be of two kinds. If the eyelids are swollen, and florid, and tender, and there is a thick yellow secretion about the lids, and the conjunctiva is red, swollen, and chemosed, the inflammation is acute, and requires to be treated by bleeding and purging. But if, as Mr. Tyrrell shows, the palpebræ are not much discoloured, and are œdematous, and if the secretion is thin and light-coloured, and the conjunctiva œdematous, the patient will be benefited by good broth, carbonate of ammonia, and opium.

II. DISPLACEMENT, OR COUCHING.—The object of this operation is to remove the cataract from the axis of vision. It is a clumsy and violent operation, and adapted only to those cases of hard cataract, of which the extraction would be unadvisable, for reasons mentioned in a preceding page. The disadvantages of it are, that the pressure of the lens on the ciliary processes and retina is liable to be followed by protracted inflammation or amaurosis; and that the lens may rise again to its old place, and obstruct vision as before. The preparation of the patient, his position during the operation, as well as that of the

surgeon, and the duties of the assistant, are the same as required for the operation of extraction. The pupil should be dilated with atropine.

Operation.—A curved needle is passed through the outer side of the sclerotic, the $\frac{1}{10}$th part of an inch behind the margin of the cornea, and in the transverse axis of the globe. It is carried into the vitreous humour, the posterior capsule of the lens lacerated, then upwards and forwards behind the iris, and in front of the cataract; which then is readily and gently pressed upon till it is carried downwards out of sight. It should be held down for a few moments to fix it, and if it rise again, it must be again depressed for a short time. Then the needle is withdrawn.

III. The Operation for producing Absorption is very easily performed, and excites very little inflammation; but it requires to be repeated several times, and the cure occupies several weeks or months. It is well adapted for soft cataracts, especially the congenital, but does not answer with the hard cataracts of old people. The instruments employed are needles, straight or curved; which are now made of great delicacy, strength, and sharpness. The pupil must be freely dilated.

Operations.—1. The needle may be introduced behind the iris in the same manner as for depression.

2. Or the needle may be introduced through the cornea, an operation now styled the anterior operation; formerly *keratonyxis*. It is safer, simpler, less painful, and less injurious to the eye than the first mentioned: inasmuch as a wound of the cornea alone is less serious than one implicating vitreous humour, sclerotic, conjunctiva, and perhaps retina or ciliary processes. The needle is passed through the cornea close to its margin, and is made to lacerate the capsule to the extent of the pupil, so as to admit the aqueous humour to the substance of the lens; but without displacing or cutting it into fragments, or, in fact, attempting to do too much. This operation is liable to be followed by severe pain and vomiting, if the cataract be so fluid that it mixes readily with the aqueous humour: in this case the contents of the anterior chamber should be evacuated, as recommended by Mr. Dixon; or portions of the cataract may press on the iris; in the latter case, the irritation may be so severe as to render it necessary to perform extraction. The operation may require to be repeated after two or three months.

3. There is a third modification of this operation, which Mr. Tyrrell termed *drilling*. It is particularly adapted for cases of capsular or capsulo-lenticular cataract with adhesion of the pupil, caused by iritis. It is performed by introducing a fine straight needle through the cornea near its margin, and passing it through the pupil into the lens to the depth of about one-sixteenth of an inch, and rotating it freely. This operation may be repeated at intervals of four, five, or more weeks. It causes the lens to be dissolved by the aqueous humour; and if the puncture be made in a fresh place at each operation, that portion of the capsule which is behind the pupil may become loosened and detached.

This operation may also, according to Mr. Tyrrell, be occasionally resorted to, in order to diminish the size of the lens, previously to depression or extraction.

IV. LINEAR EXTRACTION consists in removing the lens through a small opening in the cornea. It was originally introduced by Mr. Gibson of Manchester; but had long fallen into disuse, when it was again brought forward by Mr. Bowman in this country, and by Professor von Græfe in Germany. A small opening is made at a little distance from the margin of the cornea, the capsule is freely lacerated, and the fragments of the lens are removed by the curette. As the use of the curette is liable to excite inflammation of the iris, Professor von Græfe commences his operation by removing a small portion of it (*iridectomy*), so as to facilitate the removal of the nucleus.

V. SCHUFT'S operation is essentially the same as that of Professor Græfe, but he has introduced several modifications, especially the use of a new form of scoop, by which he maintains that the operation, which was formerly considered as applicable only in soft cataracts, may be employed with advantage even in the hardest lenses. The removal of a portion of the iris, and the risk of bad consequences from the free use of the scoop, constitute serious objections to these operations in the minds of some surgeons.

OPERATION ON INFANTS.—Congenital cataracts should be operated on early—within four months, if possible, lest the eye, which, when born blind, habitually oscillates from side to side, may never acquire the power of being directed to one particular object. The pupil being well dilated, the child, narcotized by chloroform to insure quietness, should be placed on a table—the head on a pillow, and rather hanging over it—one assistant holding the legs and trunk, a second the arms and chest, a third, fixing the head between his two hands, and a fourth, depressing the *lower* eyelid with one hand, and steadying the chin with the other. The operator then, seated behind the patient, performs the operation for absorption as before described. Care must be taken not to dislocate the lens. The operation on children, and, in fact, on persons under twenty, generally excites so little inflammation, that both eyes may be operated on at once, but the bowels must be kept open, and leeches should be applied if there be pain.

CAPSULAR CATARACT.—When congenital cataract of the capsulo-lenticular sort is left to itself, the lens often becomes absorbed, and the capsule, which is mostly tough or opaque, remains in the field of vision; and it sometimes happens that an opaque capsule is left, or that it becomes opaque after one of the operations for cataract. There are three plans of treatment. 1. *One* needle, or better, two, as recommended by Mr. Bowman,* may be introduced, as for depression; and then may be made to tear through the opaque capsule, which then may shrink and leave the pupil clear. 2. The upper part of the capsule, for four-fifths of its circumference, may be detached by the needle from the suspensory ligament, and then be pushed down below the

* Med. Chir. Trans. vol. xxxvi.

no other plan succeed, an opening may be made in the
h which it may be extracted by means of a small hook
Mr. Middlemore has proposed a plan for removing such
the sclerotic.
eat uncertainty of clearing the pupil of capsule by any
t extracting it, yet so dangerous has that operation been
the escape of the vitreous humour, which is almost sure
previous operations have been done within the eye, that
is seldom attempted. To meet this difficulty, Mr.
n has introduced into practice a peculiar sort of forceps
al of the capsule. The instrument is no larger than a
the opening in the cornea need not be larger than neces-
of the exit of the strip of capsule to be removed, and all
to extraction are overcome.

SECTION XII.—GLAUCOMA.

, as it is now understood, means a disease which gradually
tissue of the eyeball, and, if it cannot be arrested, ter-
organization and total blindness. It occurs in an *acute*
form, and its victims are generally elderly people, of
ken-down constitution.
coma comes on suddenly, with violent neuralgic pain in
throughout the ophthalmic branches of the fifth nerve.
loss of vision. Perception of light may be gone in a few
in a few hours. The cornea is dull and steamy; the iris,
coloured, is bulged forward by posterior pressure against
ie pupil is dilated and fixed; the sclerotic discoloured and
versed by large tortuous veins, purplish, or of a dull-red
eball is of stony hardness. The extremely violent cases,
n is lost in a few hours, are separated into a class by
Græfe, as *Glaucoma fulminans*.
nportant to recollect that the outburst of acute glaucoma
ceded during a period of varying duration by premoni-
ns: these are, rapidly increasing presbyopia, prismatic
e flame of a lamp or candle, slowly progressive contrac-
l of vision, dull, aching pain; increased tension, &c. To
om very great importance is attached by Mr. Bowman.*
ucoma.—In chronic glaucoma the disease proceeds slowly
y. Pain, if present, is only occasional; the cornea be-
uch flattened, and in a great measure loses its sensibility.
examined with the ophthalmoscope while the lens and
till clear, there will be found excavation of the optic disc,
tion of the central artery, and sometimes small dotted
the retina. There is stony hardness of the eyeball;
the lens becomes opaque, and all the tissues more or
ed.

* Brit. Medical Journal, Oct. 1862.

PATHOLOGY.—The pathology of glaucoma has been carefully investigated by Professor von Græfe and by Mr. Hulke, who arrive at nearly similar conclusions. Professor von Græfe says: "I consider acute glaucoma to be a choroiditis (or irido-choroiditis), with diffuse exhibition of the vitreous body (and aqueous humour), and in which increase of the intraocular pressure, compression of the retina, and the well-known series of secondary symptoms, are produced by the increased volume of the vitreous humour."

TREATMENT.—Until within the last few years, chronic glaucoma was considered as beyond the reach of treatment; abstinence from exertion of the eye, and attention to the general health were recommended as palliatives. In acute glaucoma, leeches, cupping, mercury, opium, &c. relieved the pain and sometimes cut short the paroxysm; but the result was always the same: each attack left the vision more impaired, and sooner or later it was totally lost. In 1857 Professor von Græfe described a new operation which he termed *Iridectomy*, and by which he maintained that the abnormal tension of the eyeball is completely and permanently removed, and the disease arrested and cured. Since its introduction this operation has been extensively tried in this country and abroad, and has excited much discussion. As it consists merely in removing, after a peculiar fashion, a small portion of the iris, its *modus operandi* is not evident; hence it is still strongly opposed by some eminent surgeons. The extensive experience of others, however, has led them to be satisfied with the results, even though they could not fully explain how they were arrived at; and it certainly seems that even a more formidable operation would be justifiable in such an intractable and destructive disease. It is now established, in the opinion of the great majority of surgeons, that iridectomy is advisable under the following circumstances:—

In the Premonitory Stage, when the intermissions are no longer complete, when the exacerbations are frequent, the tension permanently raised, the field of vision contracting. In such cases, if the operation be performed before structural changes have taken place, complete success may be expected.

In Acute Glaucoma, when there is a fair quantitative perception of light. The sooner the operation is performed the better, as in severe cases, destructive changes take place with great rapidity. When performed early, under favourable circumstances, permanent recovery may be expected; when delayed, the prognosis varies according to the extent to which degeneration has taken place.

In Chronic Glaucoma patients seldom apply until considerable degeneration of tissue has taken place. This, iridectomy does not profess to remedy; but, according to the condition of the eye, we may expect improvement to a variable amount, and, at all events, arrest of the disease, with retention of what sight remains.

Those who wish to study this very important subject more fully will find a translation of Von Græfe's papers in the Sydenham Society's volume for 1859; Mr. Hulke's paper in the Med. Chirurgical Trans-

and many papers in the medical journals. A lively
hich everything that can be said for and against the
found in the British Medical Journal, from Sept.
une 11th, 1864; and a very able and temperate
hole subject in four lectures by Mr. Soelberg Wells,
d its cure by Iridectomy."

orming Iridectomy.—The patient having been chloro-
ds fixed with the spring speculum, and the eye
the conjunctiva with a pair of forceps, an opening is
erior chamber by means of a lance-shaped iridectomy
ld be entered about half a line from the junction of
e sclerotic, great care being taken not to wound the
rior chamber be very small from great bulging for-
t will be safer to use a narrow extraction-knife in the
queous humour should be evacuated very slowly, and
a pair of fine forceps and carefully divided by the
e ciliary margin, from one-fourth to one-sixth being
w pupil may be made in any direction; but for many
d one, though slightly more difficult of performance,

TION XIII.—THE OPHTHALMOSCOPE.

ient is to the eye what the stethoscope is to the chest.
dered obsolete nearly all that had been written on the
s of the eye; for it has been the means of detecting
anied with any objective symptoms, and not known
exist. Its use is quite indispensable in all cases of
t attended with extreme intolerance of light. Very
a patient complain, from the use of the instrument,
which such a result might fairly be expected, and
by ordinary caution.

lmoscope, in its simplest form, is a concave circular
inches focus, made of silvered glass or polished steel,
in the centre. As an appendage there is needed a
h and a half in diameter, with a focus of from two
ee inches, set in a common eye-glass frame with a
long. The investigation must be made in a dark
t's pupil should be dilated as a rule. The light of a
ufficient, certainly not for beginners. An oil lamp
far the best is an argand burner that slides on a

by a table, and the lamp is placed by his side close
the flame on a level with the eye, from which it is
flat plate of metal attached to the burner. The
ly in front; and, holding the instrument close to his
fiquely to catch the light from the lamp, he com-
nce of about eighteen inches from the patient, to

direct the reflection on the eye. When this is got, the convex lens must be held at the distance of two and a half inches from the eye and the focusing commenced, by moving them slowly backwards and forwards. When the light fairly enters the eye a reddish glare appears, and as it is focused, an orange-red or orange-yellow is seen; then the blood-vessels of the retina come into view. The retina itself presents a whitish aspect, through which the choroid is more or less discernible. The entrance of the optic nerve should now be sought; probably a part of it will already have been seen as a whitish spot: but the way to discern it properly is to make the patient look inwards. It appears as a whitish circular spot, in the centre of which are the central vein and artery of the retina, giving forth a variable number of branches, usually six or eight.

The convex lens is not usually needed for examining near-sighted eyes, nor, in general, for the anterior structures of the eye. The annexed sketch (fig. 1) illustrates the above description, and accurately

Fig. 1.

shows the proper position of the lamp, the direction of the patient, and the slightly-raised position of the observer.

III. But what is the principle of the ophthalmoscope; why is a reflector needed; why cannot the eye be illuminated with the very lamp

from which the light is borrowed? When a stream of light is thrown into the eye, the rays are reflected back by the retina and choroid, and, returning as they enter, are brought to a convergence at the spot whence they emanated. This takes place when any luminous body is held before the eye; hence when a candle or lamp is used, we see no illumination, simply because the flame is in the focus of reflection, and our eye cannot be there too, nor can it see through the flame. This difficulty is overcome by using a mirror with a hole in the centre (the ophthalmoscope), which represents the flame, and, by looking through the hole, we place our eye in the centre of the reflection, and thus see the lighted interior of the patient's eye. It is possible by certain arrangements of light, and position of the beholder, that the eye may be to an extent seen illuminated; but for the full effect, the ophthalmoscope is requisite.

IV. HEALTHY APPEARANCES.—The *arteries* and *veins*—the latter being larger and darker—radiate on the retina, and branch and anastomose almost to the ora serrata. No vessels cross the situation of the macula lutea.

It is not uncommon in eyeballs that are diseased to see the pulsation of these vessels; sometimes it may be seen in health, especially if the eyeball be pressed. Mr. Hulme has a patient attending at the Central London Ophthalmic Hospital, with pulsating retinal vessels, although the sight is unimpaired.

The *Choroid* must be focused to be examined. The irregularly arranged markings of a dusky hue indicate the vessels. The coloration of the choroid is darker in persons of a dark complexion, and of a lighter and less distinct shade in those of a fairer skin.

The *Retina* is a perfectly transparent colourless structure, and is best recognised by means of the vessels which pervade it. The arteries are of a smaller calibre, and have a more direct course than the veins, which are more tortuous, and of a darker colour, derived from their contents; but this last feature is not always well marked.

The *Optic Disc*, or termination of the optic nerve, as it enters the sclerotic, is the most important part to be noted in an ophthalmoscopic examination. In health it is circular in form, of a bright white colour, and perforated generally in its centre, but frequently in different parts of its surface, by three or four arteries entering the globe for distribution, and by as many veins which leave the interior of the eye. (See fig. 2.) A slight hyperæmia of the disc is not incompatible with healthy vision.

The *Macula Lutea* is that part of the retina which lies directly in the axis of vision, and which is brought into view by causing the patient to look directly forwards. Frequently there is no particular structure to be made out, and the part is generally recognised by the absence of the retinal vessels, which seem to avoid this situation. Sometimes a paler, and at other times a darker appearance are the only indications of it. It must, however, be borne in mind that it is often the seat of hæmorrhages, morbid deposits, &c., which are always

more or less detrimental to perfect vision. It should therefore be carefully examined.

Fig. 2.

The *Vitreous Humour*, the aqueous, the lens, and its capsule, and the cornea, are all parts which in the healthy state of the eye are transparent, and admit of a clear definition and observation of the whole of the posterior part of the interior of the eyeball.

V. MORBID APPEARANCES.—Such is a description of the parts seen by the ophthalmoscope in the healthy state. We now propose, for the guidance of the student, to give an outline of the morbid appearances to be observed, premising that a thorough knowledge and use of this instrument can only be acquired by most careful practical study.*

The *Optic Disc* is the first point to which attention should be directed in an internal examination of the eyeball. The changes in the disc itself are so frequently connected with changes in the parts around its circumference, that during its examination, the state of these circumferential parts must be carefully noted.

Hyperæmia of the Disc is of very frequent occurrence; the retinal vessels may be enlarged and dilated, and the veins varicose; in addition to which the surface of the disc may be seen finely injected, instead of showing its white normal appearance. This injection may proceed to

* To those interested more especially in the diseases of the eye, as revealed by the ophthalmoscope, the following works are recommended for study and reference:—Edward Jaeger; Beiträge zur Pathologie des Auges, folio, Vienna; Ruete's Bildliche Darstellung der Krankheiten des Menschlichen Auges, folio, Leipzig. Desmarres, Maladies des Yeux, vol. iii., 1858; the Ophthalmic Hospital Reports, and Messrs. Taylor and Hulme's Ophthalmoscopic Sketches, now publishing serially in the Archives of Medicine.

extent as almost to hide the disc (fig. 3). Hyperæmia of the common in those cases of impaired vision from overwork, which

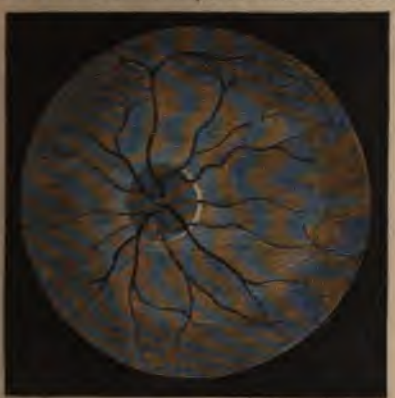


Fig. 3.

with in the case of engravers, compositors, sempstresses, &c. may be effused on the surface of the disc, constituting what has alled apoplexy of the papilla. Black pigmental deposits are ually seen on its surface, and frequently at its edge. The disc sent a cupped appearance, as in glaucoma, where it is said to be ve of intra-ocular pressure; or an elevated appearance of its The form of the vessels entering and leaving the centre, and ure of the shadow, as shown by varying the light, will be the ans of ascertaining in these cases which state is present.

phy of the Disc is far from uncommon; it is often congenital; metimes found in a squinting eye, and is often associated with e myopia. In cases of atrophy of the disc, the retina generally es its normal condition and vascularity. The optic disc does not preserve its circular form; it is occasionally jagged in its out- l pigmentary deposits are of frequent occurrence at its edge. e choroidal degeneration which is often seen around its circum- and from the white shining appearance of the sclerotic through a, the edge of the disc may be but indistinctly defined, and the ic patches of sclerotic may be confounded with the outline of by the beginner; but to the practised eye the outline may be distinguished.

Retina.—Its transparency should be unimpaired, and its vascu- ot greatly different from that of the healthy state. If the disc emic, it will naturally partake of the extra vascularity, but not ; for the disc may be injected with small vessels, while the re-

tinal vessels are natural. Its vessels are subject to varicosities; and a certain indistinctness of outline is frequently observable in its over-loaded veins. The arteries often show plastic exudations in their course which have evidently been deposits during an inflammatory stage (fig. 4). Extravasations of blood are occasionally seen from the rup-

Fig. 4.

ture of one or more of the vessels (fig. 5); the gradual absorption of

Fig. 5.

which may be watched. Serous effusions between the retina and cho-

roid are attended always with more or less danger to sight, according to the locality and amount of the effused fluid. The retina may be seen, floating as it were, or lying in folds over the part, the bright-red choroid of course being hidden from sight. As the effusion is over or near the macula lutea, so is a more unfavourable prognosis to be feared. The retina is often anæmic and even atrophied. M. Desmarres describes an affection which he calls œdema of the retina. It is doubtless affected in secondary syphilis.

The Choroid, as may be anticipated from the vascularity of its structure, is most importantly involved in chronic changes in the deep-seated structures of the eye; and although we are by no means disposed to draw any strict line between the inflammation of the different tunics of the eye, as existing independently of each other; yet this structure shows changes so marked that the effects of choroiditis may be safely classed under one head. The principal affections of the choroid are hyperæmia; when, instead of its usual somewhat orange-red colour, it becomes of a bright scarlet, the vessels are enlarged, and the pigmental striations are more or less indistinguishable. The absorption of the pigment from some parts causing white patches, and its redeposition in others forming the black deposits so often met with, are signs of the atrophy and disorganization of this important structure. These black deposits may take place at any part of the fundus, but they are most frequently met with around the edge of the optic disc. They are always situate between the choroid and retina.

Atrophy of the choroid when occupying the situation of the macula lutea, is always attended with considerable impairment and confusion of vision, and is of course irremediable. Plastic exudations from its surface, pushing the retina forwards, are sometimes seen. The appearance of an eye which has been the subject of chronic choroiditis is most striking. The black, white, yellowish, and red variations of colour have been described by Desmarres as the *Choroide tigrée*.

Effusions of blood from the surface of the choroid may take place, and probably many of the deposits on its surface have had this origin. Colloid degeneration has been described by Donders.*

An affection often met with in short-sighted persons, and involving both the choroid and sclerotic, must be noticed. The sclerotic is thinned at the posterior part of the eyeball, and bulges backward into a conical shape, carrying the choroid with it, and thus altering the antero-posterior diameter of the eye. It has been denominated sclero-choroiditis posterior. It generally takes place near the optic disc, and appears as a semi-lunar white patch, which more or less completely surrounds the optic disc. That the retina is perfect over this white patch is evident from the retinal vessels being continued over it in their normal size and distribution.

The Macula Lutea may be the seat of morbid deposits, hæmorrhages, and plastic exudations. Small vessels sometimes enter about

* Archiv. für Ophthalmologie, 1855-6.

these parts abnormally. All alterations from the healthy state in these structures are more or less detrimental to vision.

The vitreous humour is often the seat of hæmorrhage. Floating particles may exist in its substance, which is generally more fluid than in its normal state, or a greater or less degree of turbidity may interfere with its transparency, and envelope in a fog the parts posterior to it. Cholesterine scales may be seen floating about in it, and the cysticercus is occasionally seen in its substance. The vitreous humour should be thoroughly examined both with and without the lens. Floating particles and alterations in its anterior portion are best seen with the mirror alone.

The use of the ophthalmoscope in diagnosing cataract in its incipient stage must be very evident. It is necessary that the pupil should be fully dilated with atropine. The frequency with which cataract commences in striæ at the edge of the lens, makes it impossible to state with any precision the condition of the whole structure with an undilated pupil. The striæ, which were undiscernible before the introduction of this instrument, are recognised with the greatest facility, appearing as black markings on the red field of the choroid. By fully dilating the pupil, also, we are able to examine well the capsule of the lens, which is often rendered spotted by deposits of uvea from the surface of the iris, and thus gives rise to muscæ and indistinctness of vision.

SECTION XIV.—DISEASES OF THE CHOROID; ASTHENOPIA; SYNCHYSIS; AND HYDROPHTHALMIA.

I. INFLAMMATION OF THE CHOROID, or CHOROIDITIS, is not a common disease; Dr. Mackenzie has generally met with it in strumous females.

Symptoms.—It commences with more or less intolerance of light, and dimness of vision, together with pain in the eye, eyebrow, and forehead, and lachrymation. The conjunctiva is not uniformly red, but one or more enlarged vessels are seen to proceed from the back of the eye, and to terminate in a vascular zone partially surrounding the cornea. The pupil is often displaced, and brought towards the affected side of the choroid. If it proceed, the sclerotic becomes thin and blue, showing the choroid through it—(*staphyloma sclerotiœ*), and finally the cornea may become opaque, and the whole globe very much enlarged and protruding from the socket. The digestive organs are generally much deranged from the first, and hectic and emaciation come on when the eye becomes much distended and painful. See ophthalmoscopic appearances of diseased choroid, page 437.

Treatment.—If an acute case of the sort should occur in a strong constitution, local bleeding, purgatives, blisters to the nape of the neck, and warm or vapour baths, and mercury, may be necessary. But in cases of debility, great caution must be used in regard to depleting measures and mercury; and together with the latter some tonic should always be given. Counter-irritation is always of service. When the

sclerotic becomes much distended, it may be punctured with a needle —the instrument being introduced for one-eighth of an inch towards the centre of the eye, so as not to wound the lens; this will cause temporary relief.

II. Weakness of Sight, or Asthenopia: Muscæ Volitantes. —Persons of delicate constitutions and sedentary habits, especially if they are in the habit of writing much, or otherwise exerting their eyes on minute objects, are liable to suffer from dimness of sight; uneasiness on exposure to a strong light; and the vision of floating black specks or streaks, which, from their resemblance to flies, have acquired the name of *muscæ volitantes*. In one form of the affection the patient is unable to continue for any length of time to look at minute or near objects; partly on account of the confusion and obscurity which overspread them, and partly from a sense of fatigue in the eyes. A short interval of repose is sufficient to recruit the eyes, so that the power of vision returns. The disease is apt to increase unless the particular employment that seems to produce it be abandoned, but it never ends in total destruction of sight, and must not be confounded with amaurosis. It is often improperly called *Choroiditis*. These symptoms evidently depend on weakness of organization, either original or produced by overexertion; and the principal measures to be adopted are tonics, aperients, shower-bathing, and change of air, with perfect rest of the eyes, which afterwards should not be used too long at a time. It is almost always associated with hyperemia of the optic disc; see page 437. Weakness of sight, with intolerance of light, is very commonly an accompaniment of short sight; it may always be recognised by an uneasy bashful look about the patient's eyes, the lids of which are half-closed, and perpetually winking, and the brow contracted. Dr. Mackenzie has shown that the appearance of muscæ is caused either by globules of mucus on the surface of the cornea, or by minute particles floating within the eyeball.* This is confirmed by the ophthalmoscope, although in all cases the floating particles cannot be seen.

The surgeon should take care not to mistake the effects of mere fatigue of the eyes, such as aching, increased vascularity, intolerance of light, and muscæ, for inflammation; and not to treat such symptoms indiscriminately by depletion.

III. Synchysis (often attended with shrinking of the eyeball) is an unnatural fluidity of the vitreous humour, apparently from the breaking up and absorption of its containing tissue; it may or may not be also discoloured. The eye feels soft and flaccid, the iris is peculiarly tremulous, shaking backwards and forwards like a rag in a bottle of water, the retina becomes insensible, and the lens opaque. This affection is sometimes the result of wounds or concussions, and sometimes comes on without obvious cause. It is supposed to depend on slow inflammation. It is irremediable. It sometimes follows operations for cataract in which the needle has been too freely used. But although

* Mackenzie, Edin. Med. and Surg. Journ., No. 164.

there is this great change of structure, vision may still be wonderfully perfect. For the ophthalmoscopic changes see page 438.

IV. DROPSY of the vitreous humour, or HYDROPHTHALMIA, probably depends on slow inflammation of the inner tissues of the eyes, generally the result of injury. It causes enlargement of the globe, with loss of sight. In some cases there is constant excruciating pain, only to be relieved by puncturing the sclerotic with a needle. In others, there is no pain; the disease advances a certain length, and then becomes stationary; and the only thing complained of, besides the loss of vision, is the deformity.

SECTION XV.—RETINITIS.

THE RETINA must of necessity be more or less involved in any inflammatory process which affects the deeper structures of the eyeball; but sometimes it appears to be the original or sole seat of inflammation. That inflammation may be confined to the retina, without affecting the other textures of the globe, is rendered probable by the distribution of the arteria centralis retinæ, and its very slight vascular connexion with any other tissue.* Authors describe three forms; the acute, subacute, and chronic. 1. In the *acute* form the symptoms are—severe, deep-seated, and throbbing pain in the eye, extending to the temples and head; vision rapidly impaired, or even altogether lost; frequent sensations of flashes of light, with great fever and delirium. The pupil gradually closes, the iris loses its brilliancy, and the sclerotic is highly vascular and rose-red. If unrelieved, the whole globe may suppurate. 2. *Subacute.*—Dimness of sight, headache or giddiness, flushed countenance and fever; the pupil soon becoming motionless, and the iris turbid. 3. *Chronic.*—Gradually-increasing dimness of sight; visions of black spots or flashes of light; irritability of the eye and intolerance of light; tenderness of the eyeball, and of the parts around; but the patient, though he may shade the eye, does not always shut it. These affections are distinguished by the circumstance that dimness of sight and intolerance of light occur before redness or any external sign of inflammation. But the practitioner must carefully discern between these symptoms and the intolerance of light, or photophobia, which occurs in *Strumous Ophthalmia*, as the treatment for the two complaints should be diametrically opposite. The age of the patient, and the fact that in Strumous Ophthalmia the sufferer has periods of remission, and can usually open the eyes towards evening, will sufficiently mark the difference; besides, in acute *Retinitis*, there is deep-seated pain felt at all times, while in Strumous Ophthalmia the pain is very little felt, so long as light is completely excluded. See retinal changes, page 435.

Causes.—Exposure to vivid light, flashes of lightning, strong fires, the reflection of the sun from snow, and the like; or habitual exertion of the eye on minute objects, together with neglect of exercise, confinement of the bowels, and over-indulgence in food and spirituous liquors, or else with debility, and want of nourishment.

* Taylor, Med. Times and Gaz., June 5th, 1852.

osis.—If, in the acute or subacute form, vision is not much
, nor the iris altered, nor the pupil much contracted, the pro-
ay be favourable.
ment.—For the acute, local bleeding, purgatives, mercury ad-
d as as gently to affect the mouth; for the chronic form, a
urse of mercury, and the antiphlogistic treatment generally,
to the urgency of the symptoms, and the strength of the
The eyes should not be closely covered, but the patient
kept in a darkened apartment, observing at the same time that
roughly ventilated. So soon as the symptoms abate, bark and
f air will be found of great service.

SECTION XVI.—AMAUROSIS.

tion.—Imperfection of vision, depending on some change in the
ptic nerve, or brain.
toms.—1. Of course the first and most prominent symptom is
nt of vision; the mode and degree of which are, however,
o very great variety. Sometimes the sight becomes suddenly
is soon extinguished altogether; more frequently it becomes
by slow degrees; and at first it is so only at intervals; after
have been fatigued, for instance, or when the spirits are low,
tomach disordered. Sometimes it commences as indistinct
amblyopia; or as *diplopia*, objects appearing double; or, as
, one-half only of the objects looked at being seen; or objects
ear crooked, disfigured, or discoloured; or they may be seen
with patches; or the affection may commence as near-sighted-
ar-sightedness. The patient finds himself unable to estimate
, and misses his aim when trying to snuff a candle, or pour
o a glass. The flame of a candle generally appears split,
ed, or broken into an iridescent halo.
ular spectra, sometimes in the form of floating black spots
olitantes), sometimes as flashes of light, or as a coloured cloud
rk.*
metimes incipient amaurosis is attended with great intolerance
—sometimes, on the contrary, with a constant *thirst for light*,
as if objects were not illuminated enough.
e patient walks with a peculiar uncertain gait, and his eyes
racant stare; the eyelids move imperfectly and seldom—the
generally dilated (unless it be an incipient case attended with
ce of light); the iris moves sluggishly, and in confirmed cases
motionless. But if one eye be sound, and be exposed to light
he examination, the pupillary movements may not be lost.
phthalmoscope enables us to state with tolerable accuracy when
e is strictly cerebral; for if with impairment or loss of sight,
ooks perfectly healthy, we may without much doubt say that
se is within the skull.

* student will do well to read Milton's account of his own blindness, as
Dr. Johnson's Lives of the Poets, and in Travers's Treatise on the Eye.

Whenever the state of the eye will admit it, the ophthalmoscope should be used not only for diagnosis, but to ascertain the arrest or the progress of the affection.

Diagnosis.—Amaurosis may be distinguished from cataract by noticing, 1. That, in cataract, an opaque body can be seen behind the pupil, and that the impairment of vision is, for the most part, in proportion to the extent of that opacity; whereas, in pure amaurosis, in *young persons*, the pupil shows its natural colour. A greenish colour of the pupil has sometimes been considered a diagnostic mark of amaurosis. On this point, says Mr. Walton, "the paleness or light yellowness, that exists behind the pupil after middle life, is often thought to be symptomatic of amaurosis; it is, however, but the effect of the coloration of the lens, and is seen with or without defective nervous power: young persons with amaurosis never exhibit this appearance. It is this coloration that produces so much difficulty in diagnosis in adults;" and unless the symptoms be taken into account, it is often impossible, from the mere look of the pupil, to determine between the earliest stages of the two diseases. 2. That, in cataract (with the exception of the radiating variety), vision is simply *clouded*, and that a lighted candle appears as if enveloped in a mist; whereas, in amaurosis, objects are seen *dis*-coloured or perverted in shape; and that a lighted candle seems split, or lengthened, or iridescent; and that *muscæ volitantes*, and flashes of fire when the eyes are shut, are not present in pure cataract. 3. That, in cataract, vision is better in a dull light, whereas it is generally the reverse in amaurosis. 4. That a patient with cataract is always able to discern light from darkness, and that he looks about him, and moves his eyes, as though conscious that vision still exists, although he may be unable to discern particular objects; whereas, in confirmed amaurosis, there is the fixed vacant stare of utter darkness, and the eyeball is protruded and motionless. 5. That in pure amaurosis in young persons, before the lens has begun to change colour, the three images of a candle are as distinct as in the healthy eye, which is not the case in cataract. In the aged, says Mr. Walton, the catoptric test may enable the surgeon to compare the existing degree of opacity, with the amount of imperfection of vision; for instance, he may judge the case to be amaurotic if the degree of blindness is great, out of all proportion to the degree of opacity of the lens; but the ophthalmoscope will be found the greatest aid to diagnosis.

Prognosis.—This is generally unfavourable—unless the disease depends on some palpable cause which admits of removal, and unless the remedial measures employed very soon produce good effects.

Varieties.—Amaurosis has been divided into the *functional* and *organic*; the former depending on some sympathetic or other disorder which does not primarily affect the structure of the nervous apparatus of the eye—the latter on organic disease.

Causes.—The usual causes of amaurosis are circumstances that overstimulate and exhaust the retina; such as long-continued exertion

of the eye on minute objects; or exposure to glaring light, especially if combined with heat—and these exciting causes are particularly aided by intemperance, stooping, too much sleep, and any other circumstances capable of producing determination of blood to the head. Amaurosis may also be a consequence of anæmia, and want of power; of organic change, inflammation, concussion, compression from extravasated blood, fractured bone, morbid effusions, tumours, or aneurisms—whether affecting the brain, optic nerves, or eye.

Treatment.—The indications in every case are, 1. To rectify any palpable disorder—inflammation or plethora by depletion; debility by tonics; bad habits, if possible, by moral means. 2. To neutralize determination of blood to the eye or head by counter-irritation. 3. To stimulate and restore the excitability of the retina. For practical purposes it will be convenient to classify the disease under the five following heads, viz., 1. Inflammatory; 2. Atonic; 3. Sympathetic cases; 4. Those produced by poisons; and 5. By organic disease.

Inflammatory.—If amaurosis be attended with any of the symptoms of retinitis, iritis, or choroiditis, that have been before enumerated, leeching or cupping from the temple or mastoid process may be performed at intervals. The bowels should be well cleared, the diet should be devoid of alcohol, and all employment of the affected organ, and all violent bodily exertion, should be desisted from. Mercury should be administered so as to bring the system gently under its influence. (F. 64.) Counter-irritants of all sorts are beneficial; blisters, or the tartar-emetic ointment applied behind the ears or to the nape of the neck; immersion of the feet in hot water and mustard; or an issue in the arms in chronic cases. In cases where gout is evident, colchicum; where rheumatism, iodide of potassium; where scrofula, cod-liver oil and iodide of iron may be beneficial.

2. *Atonic* amaurosis may come on at the close of any exhausting illness, or may be produced by great loss of blood, menorrhagia, immoderate suckling, leucorrhœa, excessive venery, or other debilitating circumstances. It has been frequently noticed after diphtheria.* It may be distinguished by its being attended with debility, pallid lips, weak pulse, dilated pupils, and an anæmic state of the retina; and the patient generally sees best after a meal or a few glasses of wine, and in a strong light.† The *treatment* consists, first, suppressing any habitual discharge, or other source of exhaustion. Secondly, in strengthening the system by change of air, tonics, quinine, steel and zinc, and especially by good living. At the same time the abdominal secretions should be well regulated by aperients (such as aloes and rhubarb), that act copiously, but not drastically; and the cutaneous and general circulation be promoted by exercise and bathing, especially the shower-

* See Med. Times, 1859, vol. i. p. 659.

† The *nyctalopia*, or *night blindness*, of the woodmen in Canada is an example of insensibility to all light save that of the sun. The moment the sun sets, there is total blindness till daylight. It seems to be caused by hard work and poor monotonous diet, and to be allied to scurvy.—See Hinde's Travels in Labrador.

bath. F. 9, 13, 21, 190. It is in this form, if in any, that local stimulants are applicable—such as exposing the eye to the vapour of æther or sal volatile (a teaspoonful of either being held in the hand); stimulating snuff (F. 184), cataplasms of capsicum to the temples; friction of the forehead with cajeput or croton-oil, or with an alcoholic solution of veratria.

3. *Sympathetic.*—(*a.*) Amaurosis not unfrequently supervenes on an attack of jaundice. If there be evidence of congestion in the head, as there frequently will be, blood should be taken by cupping, whilst the abdominal disorder should be removed by appropriate measures.

(*b.*) If there be headache, vertigo, foul tongue, and other evidence of abdominal disorder, an emetic, blue pill or hyd. c. cretâ, in small doses every night; and purgatives, till the secretions are set to rights, followed by tonics and counter-irritants, are the requisite measures. In similar cases, some foreign authors recommend the use of Schmucker's or Richter's *resolvent pills*, F. 185. Turpentine, or the *kousso*, or the oil of male fern should be given if there be signs of tape-worm.

(*c.*) Amaurosis sometimes arises from irritation of the fifth pair of nerves. If it follows a wound on the forehead, the latter should be dilated, or if it have healed, the cicatrix should be cut out. Tumours of all sorts near the eye, and carious teeth should be removed.

4. *From Poisons.*—Amaurosis is liable to be induced by certain poisons, such as lead and belladonna. If the amaurosis persist after the ordinary effects of the poison have been got rid of by the usual measures, the cold shower-bath, counter-irritation, electricity, and iodide of potassium, are the remedies most likely to be of service.

5. *Organic.* — These cases are the most hopeless. If the disease has followed an injury of the head, or fit of apoplexy, or syphilis, or if there be reason to suspect a tumour in the brain, or in the course of the optic nerve, — a moderate course of mercury, or of iodide of potassium with alkalis and sarsaparilla, and with counter-irritants, should be tried, and sometimes may effect a cure. Amaurosis arising from a tumour within the brain will

* This cut exhibits atrophy of the left optic nerve and right tractus opticus consequent on amaurosis. From the Middlesex Hospital Museum.

usually be accompanied by symptoms that will sufficiently point out the hopeless nature of the disease. There is an interesting case of this kind related by Mr. Browne of Belfast, in the "Dublin Journal of Medical Science," for May, 1849, in which there was increasing amaurosis, with complete paralysis of the motores oculi nerves; after death a tumour, nearly three drachms in weight, was found in one of the crura cerebri. For other cases of amaurosis arising from organic disease, especially if there be fixed pain in the head, palsy, or epilepsy, or idiocy, the best thing that the surgeon can do will be to prevent congestion in the head by occasional depletion, and counter-irritation; to maintain the secretions of the liver and bowels; to keep up the strength by a nutritious but not stimulating diet, and to guard the patient from mental and bodily excitement.

SECTION XVII.—SHORT AND LONG SIGHT.

I. SHORT SIGHT, or MYOPIA.—In this affection parallel rays of light are brought to a focus before they reach the retina; and this may be caused either by the refracting power of the eye being too great, or its antero-posterior axis too long. It is often hereditary; but it is apt to be brought on in youth by too close attention to study, or by continued working at small objects, as in engraving, watchmaking, &c. In such cases the ciliary muscle is brought constantly into play in the adaptation of vision, and thus the curves, both of the cornea and crystalline lens, become more convex. Sclero-choroiditis posterior, by elongating the optic axis, is a not unfrequent cause. Such cases are detected by the ophthalmoscope. It is probable that in all cases of decided myopia, there is a small white crescent at the outer side of the optic disc; but when this white spot is irregular and extensive, and when there are little irregular patches of pigment sprinkled here and there, we conclude that the myopia is due to the disease in question.

Treatment.—The proper treatment for the first form of myopia is to avoid over work on minute objects, and to neutralise the defect by carefully adjusted spectacles. When it is dependent on sclero-choroiditis posterior, and the disease is progressive, very careful treatment is necessary. The eyes ought never to be employed for long at a time; heat and congestion about the eye may be relieved by the use of the eye douche; when there is considerable disease of the choroid, Mr. S. Wells recommends a prolonged course of small doses of bichloride of mercury, and the use of the artificial leech.*

II. PRESBYOPIA.—In presbyopia, owing to certain changes in the interior of the eye, probably in the lens, the patient, though he can still see distant objects distinctly, finds his vision fail for near objects. "In pure presbyopia the far point is at a normal distance from the eye, parallel rays are united upon the retina, and neither concave nor convex glasses (even after the instillation of atropine) at all improve distant vision. The eye is neither myopic nor hypermetropic. There

* On Impaired Vision, p. 73.

is, in fact, no anomaly of refraction, but only a narrowing of the range of accommodation; the near point is removed too far from the eye, and hence the difficulty of accurately distinguishing small objects.*

Far-sighted persons ought to take to the use of spectacles as soon as they find that they cannot read at the usual distance without fatigue to the eye. Lenses should be selected which cause the type to appear bright and distinct, but not larger than natural, when held at from ten to twelve inches from the eye.

III. HYPERMETROPIA.—In hypermetropia the refractive power of the eye is too low, or the optic axis is too short. The effect of either of these conditions is that parallel rays are not brought to a focus on the retina, but behind it. It is, in fact, the converse of myopia. This affection was first clearly described by Græfe, and has since received much attention from Donders. The subject is one of very great importance, as these authors have clearly shown that hypermetropia is one of the most common causes of that most inconvenient and intractable affection, asthenopia, and a very common cause of convergent strabismus. Parallel rays being focused behind the retina, it follows that even for distant vision the power of accommodation must be exerted, and when the eye is employed on near objects, as in reading, writing, &c., the rays being divergent, a much greater exertion is necessary. The ciliary muscle is thus subjected to a strain which it cannot bear, and after a longer or shorter period of employment the print becomes dim, the lines run into each other, the eye feels hot and full, so that the patient feels relief from rubbing or pressing them, and in many cases there is dull frontal headache. There are few surgeons who are not aware of the intractability of this complaint under the usual mode of treatment, and of the numbers of sempstresses, engravers, printers, &c., &c., who are more or less incapacitated by it from following their employment. It is, therefore, very satisfactory that the true nature of this affection has been discovered, and that it can be simply and effectually remedied by the use of well-selected convex spectacles, by which the ciliary muscle is relieved from all unnatural strain.

The frequent association of convergent strabismus with hypermetropia is accounted for thus: Convergence of the optic axes increases the power of accommodation; the patient, therefore, unconsciously exerts the internal recti when looking at near objects, and, to avoid the inconvenience of double vision, one is contracted more than the other, so that the image, falling upon a less sensitive part of the retina, may be mentally ignored. The habit leads finally to confirmed strabismus.

An excellent account of the varieties of abnormal or impaired vision which may be remedied by the use of spectacles will be found in the work of Mr. Soelberg Wells, on Impaired Vision, already referred to.

* Impaired Vision, by Soelberg Wells, p. 75.

SECTION XVIII.—SQUINTING.

INTING, or STRABISMUS, may be defined to be a want of paral- in the position and motion of the eyeballs.

essential *cause* of the affection is very obscure. Probably our dge is best expressed by the statement that for the most part some weakness of sight, or some want of adjustment in the axis of one eye, in consequence of which it is involuntarily turned order to avoid the double or distorted vision that would result oking at objects with two eyes of different powers.

ordinary form of squint in young persons is the *convergent*, or which the eye is turned inwards; the *divergent*, or that in the eye is turned outwards, is more rare, and is chiefly met with rly persons, for the most part from partial paralysis of the in- rectus. It occasionally happens that both eyes squint: but it s remarked that the appearance of this is more frequent than lity. A squinting patient may *change eyes* as it were: that is he habitually uses one eye only; and although he habitually e stronger eye, and squints with the weaker, yet, at times, and lly if excited, he will look straight with the squinting eye, and with the sound one. Hence, there is often some difficulty in g at first which eye is the really squinting one; a point that be determined by quietly watching the patient, and finding out eye squints habitually when at rest. Occasionally, it is true, r, both eyes converge at the same time. When one eye is dis- and *fixed*, the affection is called *luscitas*.

SES.—1. Squinting may be congenital. 2. It may be induced habits; such as the imitation of parents, nurses, or school- , if they happen to squint; or by constantly looking at spots mples on the nose; or it may follow affections (such as horde- which render motion of the eye painful, and during which the turns the eye inwards and keeps it motionless. 3. It may be by using one eye constantly to the neglect of the other. It has nown to occur after one eye has been for a long time shaded, in nence of an inflammatory attack; which shows the expediency ys covering both eyes when a shade is necessary. 4. If there s to be an opacity on the cornea of one eye, and that eye is the one, the patient will sometimes continue to use it for ordinary but for that purpose is obliged to distort it so as to remove the opacity from the visual axis. 5. Squinting, like almost every nceivable consequence of defect of nervous influence, is some- relique of fevers and the exanthemata. 6. It may be induced tation or disorder of the stomach and bowels, teething, worms, ation, and so forth; it may, moreover, be caused by fright or fits of passion; and in some children it aways appears when lth is out of order, and disappears when it is restored. Lastly, be caused by some disorder of the circulation in the brain.

Thus, it is pretty frequently the precursor of acute hyd convulsions in children; and when it is associated with one or both eyelids, and with unusual sleepiness, or torpo lect, or faltering in the gait, some mischief within the he be anticipated.

Treatment.—If the affection be recent, that is to say, than a few weeks' duration, it may perhaps be removed by judicious medical treatment, especially by purgatives, tonics (F. 37), and by abstinence from study, and plenty the open fields. Various devices have been proposed for and exercising the weak eye, by shutting up the sound goggles, placing black patches on the nose, and so forth. squint is of long standing and is habitual, and, above all, i disparity in vision, very little, if any good can be done u ternal rectus muscle is divided. This is easily performed ing manner:—The patient, if an adult, and sits in a low chair; if an unruly child, quieted by chloroform and laid on a table. ments required are a pair of blunt-point smooth slightly-curved blunt hook, and a retractor. Then the lids of the squinti held apart by a spring retractor wire s surgeon, desiring the patient to look outw up a fold of the conjunctiva with the for the lower edge of the internal rectus, a lit insertion into the sclerotic. This is snipp point of the scissors; and next the subcon lular tissue is snipped through, so as t glistening surface of the sclerotic. It must that this subconjunctival tissue is sometim to be mistaken for the muscle. The apertu should be quite small, only just sufficient f duce the blunt hook, which should next b wards between the muscle and the scler the tendinous insertion of the muscle, and th which covers it, are to be divided with

"In order," says Mr. Walton, "to secure effectually eve the tendinous expansion of the muscle, the hook should little below the level of the pupil in its ordinary state directed backwards to a sufficient distance, swept along t globe, and its point made to project just a little above the pupil." It should be the desire of the operator to of the conjunctiva than is required to insure the compl the muscle, and of this latter there cannot be the same cept the membrane be cut at the spot directed. Mr. Wal brought the edges of the conjunctival wound together b fine sutures passed through the very margin of the edges. do not cause the least irritation. They drop out about

ay. The advantages of this plan are that it prevents the of the caruncle, the falling in of which to a great degree e vacancy sometimes so marked after the ordinary operation; d union is effected instead of the slow granulating of an open and that there rarely appear any of those fungous growths that wise common. When the operation is complete, the surgeon that the patient can move the eye more freely than before in directions, but that he *cannot move it directly inwards*.

s in which, after division of one of the recti, the eye has not to its central position, Sir W. Wilde has drawn and retained it per place by means of a ligature passed through the sclerotic nt of the divided rectus, and fixed by sticking-plaster to the emple, and allowed to remain two or three days.

xternal rectus may be divided by a similar operation, for the squint; and in some instances this has been done for the relief ent, which has followed the cure of the convergent, squint. tion should be attempted when the squint depends on opacity rnea, or on cicatrices, tumours, or other mechanical causes; hould always be ascertained, before dividing any muscle, that onist is not paralysed.

TION XIX.—TUMOURS IN THE ORBIT, CANCER OF THE EYE, ETC.

ROTRUSION OF THE EYEBALL.—We have already spoken of in the eyelids; of tumours on the surface of the conjunctiva; umours resulting from disease of the lachrymal gland. We to allude to the fact that tumours, fatty, osseous, encysted, d or *sarcomatous*, as they were formerly called (which have een sufficiently examined), may occur within the orbit, caus- heir general symptoms, protrusion, with more or less displace- the eyeball, and projection at the seat of the tumour. The tumours in this situation is twofold: destruction of the eye tinued pressure; and protrusion through the roof of the orbit cavity of the skull, with compression of the brain; which e averted by extirpation so soon as the morbid growth is of a reaten mischief. Sometimes it is fair practice to puncture, or r to lay open, an encysted tumour by a free incision.

it is not every protrusion of the eyeball that is caused by For instance,—1. An excessively protruded and goggled the eyeball sometimes occurs in connexion with *anæmia*, debility, and enlargement of the thyroid gland (*Graves's* or 's disease). See *Bronchocele*. 2. *Suppuration*, or inflam- ffusion, may take place within the orbit. This may occur ternal or external to the *ocular sheath* of Bonnet and O'Fer- ayer of fascia, immediately surrounding the eye, extending posterior margin of each palpebra to the apex of the orbit, rated by the ocular muscles. Effusion may take place in the

orbit either internal or external to this sheath. If internal to it, there will be a chemosed-like projection of the conjunctiva at its angle of reflection from the eyeball to the palpebra. If intense pain, unrelieved by treatment, with shivering, indicates the presence of pus, a puncture should be cautiously made within the palpebræ by the side of the eyeball.

II. CANCER may affect the eye or other contents of the orbit, particularly during the earlier periods of life. It may occur in any form, and affect any structure; for the common opinion that it usually first attacks the optic nerve or retina, is, according to Lebert and Paget, not well founded. The scirrhous, or hard variety, is very rare; most ocular cancers being of the soft or else of the melanotic variety.

1. *Cancer within the Orbit.*—Weight, perhaps pain in the orbit, and displacement of the eye, with dimness of vision, are the earliest symptoms; which are followed by the protrusion of a tumour. Engorgement of the surrounding blood-vessels, destruction of the eyeball, adhesion of the palpebræ, protrusion of a large tumour, bleeding, sloughing, or exuding thin offensive discharge, and cancerous deposits in the cranial cavity, in the cervical glands, and in distant organs, follow in succession.

2. *Cancer within the Eye.*—After some amount of vascularity, and of other signs of derangement of the eye—or, perhaps, after it has been discovered (if the patient is a child) that the sight of the eye is lost—an examination is made, and a patch of metallic lustre, of a grayish, reddish, or yellowish-white colour is discovered deep in the eye, behind the crystalline lens. The iris is tarnished, and sluggish. As the tumour grows, and comes nearer to the cornea, it can usually be clearly distinguished as being lobulated, and covered with blood-vessels. In time, it fills the eye, and presses the iris against the surface of the cornea, the eyeball is tense and painful, and the surrounding parts very vascular. Finally, it bursts through the cornea or sclerotica; a huge fungus protrudes, and the disease arrives at a fatal termination through the stages we have just indicated.

The *diagnosis* of intra-ocular cancer is important, because deposits of

* From a drawing of a preparation in King's College Museum, with which the author was favoured by Mr. Partridge.

thy or tuberculous lymph may occur in the depth of the eye, and all the outward and visible signs of a cancerous growth. In e diagnosis of such a growth is considered by the best authori- be impossible, until time reveals whether the eye is to burst be- rotruding fungus, and the health to exhibit the decay consequent extension of cancer; or whether, on the other hand, the eyeball remain blind but unaltered; or, 2, to be the seat of scrofulous ation; or, 3, to waste and become atrophied; one of which ontingencies usually results when this peculiar appearance is the of injury or of slow inflammation in a scrofulous subject.

Melanotic cancer is common in this situation, Lebert having it in $\frac{1}{19}$ cases: it may primarily affect the orbit, conjunctiva, or erve, but, curiously enough, has not been found primarily in the choroid, where it might naturally have been expected. Mela- cancer pursues the course of soft cancer, but perhaps more ra- Protrusion of a tumour exuding a darkish sepia-like fluid, and t multiplicity of organs affected with secondary deposits, are r features.

re is at present considerable confusion existing in the use of the *melanosis*, which is often used as if synonymous with cancer. s we have before observed, *melanotic cancer* is true soft cancer, ed and infiltrated with large quantities of black pigment. On her hand, collections of black pigment may exist in natural and l structures without cancer. Patches of black pigment may be , and may remain for years on the conjunctiva unaltered.

Cancer may commence on the *conjunctiva* in the form of small ar tumours, which soon display the characters of soft cancer, or sky hue of melanosis. Scirrhus is treated of by authors, but is ely rare. Cancer, likewise, may affect the caruncle, constituting ease formerly called *encanthis*.

It may also affect the lids; but here we must note the not un- nt occurrence in aged persons of epithelioma on the lower lid; encing as a wart, lasting an indefinite time, but, if irritated, ating in incurable ulceration; yet altogether different from can- structure, and giving much more hope from extirpation. Secondly, lassy ulcer of the *lupus* kind.

atment.—The treatment of cancer of the eye comprises two classes asures: 1, the various palliatives mentioned in the Section on r; 2, extirpation, which latter is also to be regarded as palliative, in cancer of the eye, the disease (if not already developed within anium) is sure to appear there or elsewhere. It seems to be the l opinion of surgeons that it is useless to extirpate soft cancer of yeball, especially in children; but that, in melanotic cancers, tirpation of the contents of the orbit affords a greater chance of ging life; and that all superficial cancerous tumours of the ctiva should be freely extirpated as soon as possible.

. EXTIRPATION OF THE EYE is required occasionally, not only ncer but for disorganizing suppuration, and other diseases which

may render a sightless eyeball a source of great irritation. For it must be remembered that one radically diseased eyeball is liable to induce disease in the remaining sound organ. When the eyeball alone is to be extirpated, for a non-cancerous growth, Bonnet's and O'Ferrall's operation may be performed, which consists in dividing the conjunctiva, cutting through the insertion of the recti and obliqui muscles, drawing the eyeball forwards, and severing the optic nerve. Sometimes it is necessary to slit up the external commissure of the lids; but in most cases the entire contents of the orbit require to be removed.

During this operation, Mr. H. Walton places the patient on his side, to allow the blood to run away more easily. The first step is to slit up the external commissure of the lids, with the conjunctiva and adjoining skin, to a sufficient extent. The eyelids then being held apart with retractors or spatulas, the operator takes hold of the eyeball with his fingers, or with hooked forceps, cuts through the conjunctiva above and below; cuts through the levator palpebræ, dissects away the attachments of the superior and inferior oblique, and all vascular and cellular attachments to the walls of the orbit; then drawing the globe strongly inwards, cuts through the optic nerve, vessels, and muscles at the apex of the orbit, by means of a straight scalpel or pair of scissors passed along the outer wall of that cavity. Mr. Walton does not find that crooked instruments have any advantages for this last purpose over straight ones. The lachrymal gland should be taken away; bleeding should be arrested by syringing with cold water; if troublesome, by a solution of alum on lint. The lids must then be closed, and a compress dipped in cold water be applied over the face.

IV. ARTIFICIAL EYES consist of a thin scale of enamel coloured to imitate the natural eye. They are adapted for cases in which the globe is sightless and shrunken, after the removal of staphyloma, for instance. "Besides the removal of deformity," says Mr. Walton, "the presence of the false eye may be of essential service in keeping the lids in their natural position; and preventing the cilia from irritating the shrunken globe; in placing the puncta in a more natural position for conveying away the tears; in acting as a defence against intruding bodies, which are apt to be retained within the lids and to produce irritation, and as a means of keeping the cavity free from collections of lachrymal secretions."

After staphyloma or any other disease which has rendered the eyeball shrunken and sightless, if the patient objects to the trouble and expense of an artificial eye, it may be convenient to divide the levator palpebræ, in order that the lids may remain permanently closed. This may be effected by making a transverse incision in the upper eyelid just below the orbit, and seizing the belly of the muscle as far back as possible. Then a piece should be snipped out of it with scissors.*

* See Tyrrell on Diseases of the Eye, 1840; Mackenzie on Diseases of the Eye, 4th edit., 1854; Dalrymple's Pathology of the Human Eye, 1852; Bowman on the Parts concerned in the Operations on the Eye, 1849; Dixon on Diseases of the Eye, 2nd edit., 1859, and in "A System of Surgery," edited by Holmes.

CHAPTER XIII.

DISEASES AND INJURIES OF THE EAR.

SECTION I.—EXAMINATION OF THE EAR.

INATION OF THE MEATUS.—Every surgeon ought to accustom if to examine the external passage of the ear, and to become famiith its appearances, both in health and in disease. We may prethat this canal is in the adult about an inch and a half long; that urse is inwards and slightly forwards; that it presents a slight with the convexity upwards, and is narrowest about its middle, y be said to have three divisions, which differ in structure and apnce. In the first or outermost part of the tube, the passage, says '. Wilde, is "formed almost entirely of pure fibro-cartilage covered its perichondrium," and lined by the same fine dermal structure invests the auricle. "Here the skin is studded over with fine hairs pointing inwards, and also with numerous sebaceous glands llicles. It is here also more loosely connected to the cartilage than y other part of the tube; and this accounts for the fact that small mscribed abscesses occur in this part of the canal more frequently in any other. The next portion of the tube may be called the *bular* division, because in it are seated the ceruminous glands that te the ear-wax; this is about three-eighths of an inch long, and is arrowest portion of the tube." Its walls have less of cartilage, more of dense fibrous membrane in their composition, and its derlining is finer. When in a healthy state it is generally lined with which forms a ring, coating this part of the meatus. The third ast portion of the passage is generally slightly dilated, and its walls st of bone covered by a thin dermoid layer which also serves as a steum. This part of the meatus, like the membrana tympani, can be seen satisfactorily by means of a speculum, the best of which ilver tube of conical form, with its small end of an oval shape and tly prolonged so as to support itself in the meatus. The best s of making this examination is either to use the direct rays of the or to reflect into the speculum the light from a window, by s of a mirror: that used for the laryngoscope is very suitable. urgeon should take the auricle with one hand and gently draw it ards and backwards, whilst with the other he inserts the speculum as it will go without pain. Then by gently moving the large f the speculum from side to side, a stream of light may be made y on the innermost portion of the meatus, and on the membrana

Operative Ophthalmic Surgery, by Haynes Walton, 2nd edit., 1861; on the Ophthalmoscope, 1861; Wells on Long, Short, and Weak Sight, Ophthalmic Hospital Reports, from 1857; The Ophthalmic Review April, 1864.

tympani. If artificial light is necessary, a gas or other lamp or candle, with a reflector, answers sufficiently well.

When the innermost portion of the meatus is thus examined, its lining exhibits, if healthy, a "dry, pearly-white, shining appearance;" in various chronic conditions of disease it is more or less red and vascular, or it may become villous or granular like the granular conjunctiva, and secrete pus or throw off laminæ of thickened epidermis. The *membrana tympani* also is seen closing the passage obliquely; of a bright semi-transparent appearance, and slightly concave externally. It is divided into two parts by the handle of the malleus, which in its perfectly healthy state is very distinctly seen, running downwards and backwards from the "short process" above to a little below the centre of the membrane. A little behind and below the end of this bone the membrane presents a brighter spot, of triangular form, due to the reflection of the light. In morbid conditions affecting the polish or curvature of the membrane, this spot presents various changes.

SECTION II.—AFFECTIONS OF THE EXTERNAL EAR.

I. Foreign Substances in the Ear.—Children not unfrequently poke bits of slate pencil, peas, glass beads, &c., into the passage of the ear: any such body should be removed as quickly and as gently as possible, by syringing the ear with warm water. If it cannot be thus removed, it should be allowed to remain. Probably it will after a short time spontaneously fall out, or a repetition of the syringing, at short intervals, may be successful. The meatus itself may in time enlarge, and permit its exit. Foreign bodies have remained in the meatus without permanent injury for years. Except in the case of soft fibrous bodies, or substances lying just at the entrance of the passage, therefore, other instruments, which seldom succeed and almost invariably do harm, should not be used. In any case the surgeon should make certain, by an examination with the speculum, that there is a foreign body present, before he begins poking instruments into the ear, remembering that a late eminent hospital surgeon is said to have dragged out the stapes whilst fishing for a small nail, which was not in the ear after all.

II. Accumulation of Wax, mixed with hair and cuticle, is a common cause of deafness. Syringing the ear gently with warm water is an effectual mode of dislodging it. Syringing, however, is not always to be done with impunity, for if the membrana tympani be inflamed or dry, and the passage devoid of wax, great irritation may be induced by a jet of water, especially if it be forcibly injected. The condition of the membrane, therefore, ought to be previously ascertained by an examination with the speculum; avoiding the too common practice of using a probe without first ascertaining the cause of deafness. A little cotton should be inserted into the concha after syringing. The water used should be quite warm enough to be comfortable, and the syringe should hold one or two ounces; its piston should work easily

and accurately, so that no air-bubbles may be squirted in; the patient should be carefully protected by towels; and the water injected should be *clean*, and in a separate basin; the dirty water that has been already used should not be injected over again.*

A large metal syringe is the best instrument for washing out accumulations of wax; a small elastic bottle is the best for applying lotions or injections; and one of the small elastic suction-bottles with a tube, commonly known as *Margett's*, is a capital thing to enable patients themselves to pass a gentle stream of warm water into the ear, as a fomentation, in any case of pain or inflammation. This is a most soothing process. Margett's syringe is also useful for *douching* the eye.

III. CATARRHAL INFLAMMATION of the lining membrane of the meatus. This is often excited by cold or stomach disorder, and is most frequent in children whilst cutting their teeth; it may accompany strumous ophthalmia, porrigo, and other eruptions; or it may be a sequel of either of the exanthemata, or, in fact, of any weakening illness. The little patient is feverish and complains of earache; the meatus is swelled and vascular; and these symptoms are soon followed by thin yellowish discharge. A purgative should be given; during the early stage the ear should be fomented or soothed with a large bran poultice; the discharge should be constantly washed away: and if it continue after the health is restored, astringent applications must be used combined with mild counter-irritation, F. 135, 136, 140. The surgeon should not allow the parents to believe that an habitual discharge is salutary, or that there is any fear, under proper treatment, of "driving it in upon the brain."

If at any time during the treatment, an attack of acute pain and fever should come on, and the discharge should stop suddenly, leeches, purgatives, and fomentations must be resorted to, and all astringent applications be abandoned till these acute symptoms have subsided.

IV. A THICKENED state of the epidermis lining the meatus is not uncommon. The flakes of cuticle that sometimes fill the meatus, with or without discharge, must be removed by syringing with warm water; and then the membrane should be brushed over with a weak solution of nitrate of silver, and afterwards with dilute citrine ointment (F. 168) melted and applied warm with a brush. Cleanliness is of the greatest consequence, as this affection is very apt to return if it is neglected. The epidermis often accumulates in exceedingly hard masses very difficult to remove. Warm oil or a lotion of carb. sodæ should be frequently applied, and gentle syringing repeated as often as is necessary.

V. Small follicular ABSCESSES often form within the meatus, especially in persons of weakened constitution. They are exceedingly painful, and very apt to recur. The constitutional condition should be looked to. Fomentations as hot as can be borne, and the local applica-

* A simple kind of water-spout is made by Coxeter, which may be applied to the ear, and entirely prevent the patient from being wetted.

tion of opium, give the greatest relief. A small dose of morphia at night is sometimes desirable. The diluted ung. hyd. nitrat. is a valuable application. Experience does not seem to be in favour of opening them.

VI. POLYPUS.—This term includes two sorts of morbid growths. The first consist of fleshy pedunculated growths, nearly colourless, having a thin cuticular covering, unattended with pain, not appearing as the result of inflammation, and not accompanied with discharge, and usually attached to the middle glandular portion of the meatus. These are extremely rare. The others, which are very common, and which grow chiefly from the very bottom of the meatus, are consequences of inflammation, and are always attended with discharge. They are usually found of the size of a pea or bean, but may, of course, be much smaller, or may be so large as to project from the meatus. When small they are usually of a florid red colour. They consist of fibro-plastic cells, with more or less of perfectly-developed fibro-cellular tissue, and of almost structureless gelatinous substance. Cancer of the ear in an early stage may simulate polypus.

Treatment.—Polypi are generally symptomatic of other affections of the organ, especially of the deeper-seated parts, to the removal of which the surgeon's chief attention should be directed. When these affections im-

prove, polypi will sometimes waste away, or become loose and fall out of the meatus. For the most part, however, they require special means for their cure. The instruments here figured are very effective in ex-

tracting them; and their return may be prevented (counter-irritation

* Sir W. R. Wilde's *snare for polypi*: the father of the *écraseur*.

being at the same time employed) by applying lunar caustic on a fine stick, or on the point of a probe to their point of origin. Equally effective, and less liable to set up irritation, is the application of alum in the form of powder. The meatus should be regularly syringed with warm water or an astringent lotion.

In the lever forceps, constructed by the late Mr. Avery, the forceps' blades, A, when properly introduced, can be made to grasp the neck

of the polypus, by the pressure of the thumb on the button, B, which pushes forward the canula, C, so as to close the blades. These, however, are better as flat rings than as solid plates.

VII. FUNGOUS GRANULATIONS are also exceedingly common. They generally occur at the very bottom of the meatus, or grow from the membrana tympani, or from the cavity of the tympanum after the membrane has been perforated by ulceration. Sometimes the membrane is covered with florid vascular granulations, so as to resemble the *granular conjunctiva*. The common polypus is but an exaggeration of this condition.

Treatment.—The solution of nitrate of silver should be regularly applied to the diseased surface by a camel's-hair pencil, and astringent washes should be injected.

With regard to all inflammatory affections of the external meatus it should be borne in mind that they may, especially in the young, extend to the surrounding bone, and through it, or through the veins, implicate the brain. The great safeguard is a perfectly free exit for discharge. In all cases the constitutional condition needs attention.

VIII. HYPERTROPHY OF THE EXTERNAL EAR.—Dr. Graves mentions a case in which the pendant lobes of the ear became thickened and elongated through a deposit of fat into their cellular tissue; the patient died of fatty degeneration of the liver. The author has seen one or two cases in which the whole external ear was excessively enlarged and thickened. Cysts also sometimes form in the lobe, and in the insane, effusions of blood take place beneath the perichondrium.

IX. ECZEMA of the auricle is a very troublesome affection; and if it becomes chronic, is apt to produce thickening of the lining membrane of the meatus, and of the membrana tympani. The *treatment* consists, during the acute stage, in active purgation (F. 33, &c.), and warm poppy fomentations; saline and alkaline medicines, and good diet. In the later stage, the black wash may be used as an injection, and the dilute citrine ointment be smeared over the auricle at bedtime. Bark,

with liquor potassæ, or iodide of potassium, may be given with benefit, or cod-liver oil; and in obstinate cases chloride of arsenic. (F. 97.)

X. BONY TUMOURS sometimes form in and almost entirely occlude the meatus. Much relief may be given by the careful removal of accumulations of cerumen, &c., behind them, and by iodine locally applied.

XI. SEBACEOUS TUMOURS are met with in the meatus and tympanum, and are very apt to prove fatal even in early life. They contain masses of epidermoid scales surrounded by a distinct cyst, and often perforate the bone, and press upon the brain. They escape observation, inasmuch as they seem to give rise to very few symptoms. When discovered they should be laid open, the contents evacuated, and the cyst withdrawn.*

SECTION III.—AFFECTIONS OF THE TYMPANUM AND INTERNAL EAR.

I. ACUTE INFLAMMATION of the membrana tympani is so closely connected with inflammation of the tympanal cavity, or *otitis interna*, both in its causes, symptoms, and consequences, that we may treat of them together. The usual *causes* are cold, especially exposure to currents of cold air; or sea-bathing; or violent syringing or probing, or otherwise irritating an inflamed ear. These inflammations may also come on during the course of fever, and most particularly during scarlatina, and may be caused by rheumatism and gout.

Symptoms.—Sudden and intense pain in the ear; often so excruciating as to produce delirium; increased by coughing, sneezing, and swallowing; generally coming on first at night, and always worse at night; feeling of fulness in the ear; tenderness and soreness in its vicinity; *tinnitus aurium*, that is, unnatural noises of various sorts, heard by the patient; *deafness*, partial or complete (except that in some cases there is morbid sensibility to sound), and violent fever. On examination during the first stage the meatus is found more or less red, swelled and tender, and dry; the membrana tympani dull, opaque, and vascular. If the acute symptoms go on from bad to worse, suppuration occurs within the tympanum and mastoid cells, with most intense pain, and possibly facial paralysis; and at last the membrane ulcerates or bursts, and allows of the discharge of pus from the external meatus. In other more severe or neglected cases inflammation within the cranium may occur and prove fatal. See p. 377. In less severe cases, the membrane may be left thickened and opaque, and the cavity blocked up by adhesions; or there may remain an obstinate discharge, which may give rise to caries of the bone, and mischief within the cranium hereafter.

Treatment.—This disease must be combated by vigorous antiphlogistic measures. Leeches should be repeatedly applied both to the mastoid bone and in the depression immediately below the auricle between the jaw and mastoid bone, and by means of a leech glass to the orifice of the meatus itself. Fomentations and poultices should be applied.

* Toynbee, Med. Chir. Trans., vol. xliv.

and the bowels should be opened by calomel and efficient purgatives. Should the acute symptoms not be mitigated by these measures, and especially if there should be any sense of fulness, or swelling, or fluctuation over the mastoid process, an incision, an inch or more long, should be made with a stout scalpel through the periosteum, down to the bone, parallel to and half an inch from the attachment of the auricle. Blisters may be applied when the acute stage is subsiding; or a portion of the incision, if made, may be converted into an issue.

Extreme pain of a neuralgic or rheumatic character accompanying otitis may be allayed by painting with tincture of aconite, or with solution of extract of belladonna in warm laudanum, behind the auricle; and by *cinchonism*, as in treating the so-called rheumatic ophthalmia, p. 414.

In some of these cases when pus has been formed within the tympanum, or a large quantity of mucus has accumulated, which, owing to swelling of the mucous membrane, cannot find exit by the Eustachian tube, it is very desirable to perforate the membrana tympani. Irreparable disorganization of the ear may thus be prevented, and much suffering saved. A bulging outwards of the membrane from the pressure within, taken in connection with the other symptoms, would constitute the indication for this proceeding. A small thin-bladed knife, or a sharp steel probe may be used. Care must be taken not to touch the ossicula, or the internal wall of the cavity. The best position for the incision is at the lower and posterior portion of the membrane.

II. Subacute and Chronic Inflammation.—The researches of Toynbee and Wilde have shown most conclusively that by far the majority of cases of deafness are not nervous, as is sometimes thought, but depend on changes wrought in the tympanic cavity by subacute or chronic inflammation. Mr. Toynbee divides the diseased appearances in the tympanic cavity into three stages. In the *first* stage, the lining membrane retains its natural delicacy of structure, but its vessels are enlarged and tortuous; blood is sometimes effused into its substance, and sometimes lymph is poured out on its free surface. In the *second* stage the membrane is thickened and flocculent; and occasionally covered with cheesy, tuberculous, or fibro-calcareous concretions; but the morbid change most frequently observed consists of fibrous bands, which are sometimes numerous enough to occupy nearly the whole of the cavity. In some instances they connect the inner surface of the membrana tympani to the inner wall of the tympanic cavity, or to the incus and stapes; but by far most frequently they extend from the crura of the stapes to the adjoining wall of the tympanum, so that this bone is, as it were, completely enveloped in a fog of adhesions.* In the *third* stage, the membrana tympani is ulcerated, as is also frequently the mucous membrane of the tympanum; the ossicles

* These adhesions, however, do not in all cases occasion deafness; they are probably sometimes part of the natural formation of the organ. It is to be remembered, also, that mucus may dry up into membranous-looking shreds, undistinguishable by the eye from those formed by lymph. Hinton, Med. Chir. Trans., 1856, and Guy's Hospital Reports, 1863.

are discharged, and the whole middle ear disorganized; caries of the bone and abscess may follow.

The *causes* of the less severe varieties of otitis are the same as those of the acute, but of less intensity;—exposure to cold; injudicious bathing; heated and unhealthy rooms; the weak and unhealthy states of the system left by fever, or the exanthemata; the scrofulous diathesis, especially if food, clothing, and fresh air be deficient; and the gouty and rheumatic diatheses.

Symptoms.—These, unfortunately, are often so slight, that the patient gives no heed to them, till in process of time he finds himself altogether deaf in one or both ears. A slight *woolly* sensation, or occasional noises or ringing, with variable obtuseness of hearing, and slight aching, are most frequent.

Treatment.—The general indications are to improve the health; to relieve local inflammation by leeches—applied repeatedly, so long as they give relief to pain, noise, and headache—and by counter-irritants, such as small blisters, applied in succession over the mastoid bone, or to the nape of the neck. The feet should be kept warm, and the skin be cleansed by warm baths. Any diseased state of the external meatus should be remedied by the measures spoken of in the preceding section. Iodide of potassium and *mercury* are the most efficacious remedies for removing the consequences of protracted otitis. The latter should be given in small doses, long-continued, such as one grain of the hyd. c. cretâ, night and morning; or the bichloride, which is spoken of in high terms by Toynbee and Wilde. It may be given alone, or with the tincture of bark, or of steel, F. 87.

There are some forms of otitis, connected with peculiar diatheses which require notice; and especially, first, the *rheumatic*, which has been much studied by Mr. Harvey. This may be acute, and may be accompanied with general rheumatism, and may require the treatment already prescribed for acute otitis; or may be subacute or chronic. Loud noises in the ear, deafness, rheumatic or neuralgic pains about the head or face or other parts, generally becoming worse at night, and tenderness or stiffness of the scalp or neck, are the common symptoms: leeching, and colchicum given in regular small doses, with or without mercury, are the remedies recommended for the more acute cases; the iodide of potassium, guaiacum (which is strongly recommended by Harvey), with bark or sarsaparilla, for the more chronic.

Otitis may also be connected with gout,—for the treatment of which, the remarks on modified inflammation, may be consulted;—or with scrofula, or with mere debility and cachexia, in which case cod-liver oil and bark, or steel, will be of great use; or with secondary syphilis, for which the iodide of potassium and sarsaparilla, or corrosive sublimate, are the most appropriate remedies.

A very insidious form of inflammation within the tympanum is apt to exist quite unsuspected in children; especially those that are of strumous or otherwise weakly habit. The tympanum in these cases is filled, and even distended with purulent mucus, which finds no exit, owing to obstruction of the Eustachian tube. Death sometimes ensues from

n attacks of convulsions, and very few morbid conditions besides
re found. No complaint is made of the ear; but the children cry
it is washed, or they are fond of having it tickled with a pin, or
eir hands to it, or roll their heads on their pillows. They are
ften unwilling to be *jumped* in play. On examining the ear, the
rana tympani is often seen bulging, and it presents a peculiar
eddish-white appearance due to the fluid within appearing through
ounter-irritation, and tonics, especially the iodide of iron, with
food and fresh air, are the remedies.*

effect of chronic thickening of the mucous membrane of the
anum is

. ANCHYLOSIS OF THE STAPES.—This is a frequent cause of deaf-
rom the age of puberty upwards. It may be merely membranous
rigidity of the thickened membrane—or bony. Not unfrequently
e deposit of new and hard bone of ivory whiteness surrounds the
articulating surfaces of the stapes and vestibule.†

ese cases used to be set down as nervous. There is generally no
y of pain; nor does the examination of the ear exhibit much
tion of disease. There may be more or less dryness, vascularity,
traction of the meatus, or rigidity and concavity of the membrana
ani. The *adapting* power of the ear is chiefly impaired, so that
or mixed conversation is especially difficult to follow. Temporary
is often given by yawning, pulling the outer ear, or pressing on
agus. Small doses of the bichloride of mercury, or larger doses
ide of potassium, with counter-irritation, and scrupulous avoidance
rything that can favour congestion of the mucous membranes, or
velopment of rheumatic conditions, are remedies by which a large
nt of benefit may be obtained. Turkish baths may be employed.

. CARIES, or necrosis of the petrous or mastoid bones, is a fre-
consequence of suppuration within the tympanum or mastoid
Constant fetid discharge; fungous granulations choking the
s; deafness; palsy of the side of the face; dead bone felt with
robe; probably abscess over the mastoid process, or abscess
ring amongst the muscles of the neck, and pointing low down,
e symptoms. We may reiterate the injunction, that prevention
ter than cure; that an early incision down to the mastoid bone
prevent caries, but that, at all events, if matter forms, it should
once freely evacuated. A seton at the nape of the neck is often
. Any loose portions of bone should be extracted. Sir P.
pton drew from the meatus of a young lady a piece of bone com-
g the entire internal ear—vestibule, cochlea, and semicircular
, with a small portion of the inner wall of the tympanum. The
t had urgent symptoms of inflammation of the brain, with hemi-
, and total deafness of one ear, but ultimately recovered. Other
have been since recorded. The discharge should be carefully
d away by injections, as F. 136.

* Hinton, Med. Chir. Trans., 1856.
† Toynbee. Diseases of the Ear, p. 266.

V. INFLAMMATION OF THE DURA MATER, with effusion of greenish-yellow fibrine; abscess within the brain; plugging of the sinuses or jugular vein with dirty-looking fibrine, from the entrance of fetid secretion into them; and general pyæmia, may be consequences of ear disease, just as they may of fracture of the skull, p. 378, and the observations we have made on the insidious approach of mischief within the head in the one set of cases apply equally to the other.

VI. EARACHE—(*otalgia*). This term ought to be restricted to signify *neuralgia* of the ear. Genuine *neuralgia* of the ear,—occurring in fits of excruciating pain, shooting over the head and face—may be distinguished from *otitis* by the sudden intensity of the pain—which is not throbbing,—does not increase in severity,—is not attended with fever,—and comes and goes capriciously. Its *causes* are the same as those of neuralgia generally, but particularly caries of the teeth; and its *treatment* principally consists in removing carious teeth, or stopping them, and giving purgatives, followed by quinine and afterwards iron. The tincture of aconite may be painted behind the auricle. The affection is by no means common. We cannot too strongly impress on the surgeon that what is popularly called earache is an inflammatory pain, to be treated by leeches, fomentations, and purgatives.

VII. PERFORATION OF THE MEMBRANA TYMPANI may be the consequence of laceration by violence. As we have before said, this very often accompanies fracture of the petrous bone; but it may be caused also by blows on the head, boxes, as they are called, on the ear; by violent blowing of the nose, by which means a current of air is forcibly injected through the Eustachian tube; by forcibly syringing, which, as Mr. Toynbee observes, may easily rupture a thinned and dry membrane; by descent in the diving-bell; by the introduction of foreign substances; and lastly, by loud noises, especially the discharge of cannon. Sense of shock in the ear, bleeding and deafness, are the immediate symptoms. If inflammation comes on, it must be met by the measures detailed above; and if deafness continue, as a result of the aperture, it must be treated as we shall show presently. 2. Perforation is far more commonly the result of acute otitis and suppuration within the tympanum. 3. It may also result from chronic inflammation and ulceration.

The *symptoms* which indicate an aperture in the membrane are, that perhaps the patient blows through the ear in blowing his nose forcibly; or that he can taste, or perceive in his throat, substances applied within the meatus. On examination with the speculum the aperture may generally be seen; or if the patient inflate the tympanum, in the manner to be presently described, air-bubbles and mucus may be seen to issue from it.

The *consequences* of perforation, if so small that it is capable of being closed by a film of the natural moisture of the parts, may be very slight. But a large opening generally causes considerable deafness.

Treatment.—Any diseased condition should be treated as already directed; and the nitrate of silver may be applied by means

s for the last membrane. The patient can usually be taught
uce and withdraw this cotton with great nicety, by means of
or bodkin, and to place it exactly in the right spot. Whether
s to be removed twice, or once daily, or not so often, depends
cumstances. Mr. Toynbee uses, instead of cotton, artificial
es of small oval pieces of thin India-rubber.

rulent discharge, following internal otitis, the general health
improved by tonics, alteratives, and aperients; and by warm
old bathing is almost sure to be injurious); and the local
ust be treated by the cautious use of stimulants and astrin-
The ear should be twice daily, *very gently*, syringed out with
ater; and immediately afterwards a tepid lotion of alum or
of zinc, or acetate of lead, may be dropped into the meatus
filled, and after remaining there two or three minutes, be
o run out, F. 135, 136, 140.

discharge is very fetid, a lotion of two drachms of solution of
of lime to half a pint of water may be used, or F. 117; and if
is obstinate, the whole interior of the meatus may be pencilled
week with a solution of nitrate of silver (gr. v. ad ʒi.), by
a camel's-hair pencil. If the discharge, as sometimes happens,
ccoriation of the auricle, or of the neck, these parts must be
ented, and then smeared with an ointment of hyd. præcip. alb.
ems advisable not—as a general rule—to insert ointments into
us.

COLLAPSE OF THE MEMBRANA TYMPANI.—The membrane
e its normal resiliency as the result of inflammation, causing
n of one or more of its laminæ or a general weakening of the
In this condition it falls back, irregularly, towards the pro-
, or even lies in contact with it. In some cases, on the patient's
the tympanum, it starts forward, with great increase of the

conditions, but does not appear itself to cause any very considerable degree of deafness.

X. THE EUSTACHIAN TUBES, as is well known, are passages between the cavity of the tympanum and the throat, allowing the air to enter and escape from that cavity as may be required. But Mr. Toynbee has given good reason for believing that, contrary to the common opinion, the tubes are not habitually open; and that so far from permitting constant and uninterrupted communication, their orifice is always closed, except during the act of swallowing. During this act, the tensor and levator palati muscles "open the guttural orifice of the tube, afford free egress to the mucus secreted by the lining membrane of the tympanum, and allow air to enter or leave the tympanic cavity." That this is so, is rendered probable by the circumstance that the act of swallowing gives relief to the uneasy feelings in the ear experienced by persons who descend in a diving-bell; which it does by allowing the condensed air to enter the tympanum, and so to make the pressure on its inner surface equal to that on its outer. "Again," says Mr. Toynbee, "if an attempt is made to swallow, while the nostrils are closed by the finger and thumb, a sensation of fulness and pressure is experienced in the tympanic cavity, in consequence of the air being then forced, during the act of deglutition, through the open tube into the tympanum; and this sensation continues until, by another act of swallowing, the tube is reopened, and the confined air escapes into the fauces."

These things being premised, we are prepared to understand the nature of that which has been called *throat deafness*, and which depends on the morbid states of the tympanum, extending from the throat through the Eustachian tubes. In the first place, the common catarrhal deafness,—the ringing and crackling noises in the ear, with which every one is familiar; the change of sensation experienced on blowing the nose or swallowing—supplies the commonest instance. This, in most cases, is trivial, and soon gets well. But in delicate children it is often otherwise, and a slight but increasing amount of deafness remains, depending, no doubt, on a swelled condition of the tympanal membrane, and accompanied, as is natural, with a general flabby and relaxed condition of the mucous membrane of the nose and fauces. The same thing may happen to adults. This condition will be distinguished by the swelled tonsils and relaxed throat; by the aggravation each time cold is caught; by the sudden noises from bursting of mucous bubbles, heard by the patient, and by the surgeon through the *otoscope*.

This is a flexible stethoscope, one end of which, expanded into a hollow bell, is put over the patient's ear, whilst the other is applied to the surgeon's. Then, if the patient be desired to close his nose and mouth firmly, and while doing so, to make an effort as in blowing the nose, or to swallow, the surgeon may hear the shock of air against the membrana tympani if the tubes are pervious; he will hear a squeaking or gurgling sound if they contain fluid; whilst if they are impervious,

; and repeated blisters may be applied behind the ears. It has posed that the tonsils and uvula should be extirpated in es. But although it may be justifiable to remove a superficial nlarged tonsils, on other grounds, yet it is now amply proved, rgement of the tonsils by itself is not a cause of deafness; and, , that the cutting out of healthy tonsils cannot improve the besides that, there is good reason for believing, that this mu- easily performed, may have the most disastrous consequences vice, on the general health, and, as Mr. Harvey believes, on the evelopment of the generative organs. See Chap. XV.

peration of *catheterism of the Eustachian tubes*, for the purpose ng them, or of injecting warm water or air, or medicated or vapours into the cavity of the tympanum, has also been vocated. But the author cannot recommend these operations ral adoption; first, because they are painful, and because he they very seldom, if ever, do any real good; and secondly, they are dangerous, and have proved fatal in more instances . When it is considered that in some cases the bony partition the Eustachian tube and the carotid canal is almost entirely , and that in others there is but the thinnest shell of bone, or only a mere membrane between the tympanic cavity, or cells, and the cavity of the cranium or jugular fossa (all of orbid changes the author has seen in Mr. Toynbee's collection), e readily understood how the pokings in the dark at the an tube, and forcible injections of the tympanum that we read have very easily produced fatal results. Possibly the reason ischief has not been done, is, that the catheter has been mewhere, but not into the Eustachian tube. *Perforation of brana tympani*, which has been proposed, in order to allow the air to the tympanum when the natural openings in the throat erated, is another operation very seldom required. An opera-

(having before taken water into his mouth for the purpose), and during the act the surgeon squeezes the bottle, so forcing the air into the nasal cavity. Thus the Eustachian tube being opened, and the nasal cavity cut off from the pharynx, at the same time that the air is pressed in, it passes into the tympanum, overcoming, in the great majority of cases, any obstruction that may exist. This procedure carefully performed is very suitable to many of the cases of thickening of the mucous membrane of the throat which are so frequent, especially in children.

IX. FUNCTIONAL NERVOUS DEAFNESS.—Deafness is said to be *nervous*, when it depends on general torpor and debility, and is better at some times than at others, especially in fine weather, and when the patient is cheerful or excited, and the stomach in good order, and when there is an entire absence of all symptoms or vestiges of inflammation. But such a form of deafness is rare; and Mr. Toynbee has shown, that even in very old persons, in whom it is often supposed to be common, the usual cause of deafness is not defect in the nervous apparatus, but thickening, adhesions, and other effects of inflammation of the tympanal cavity.

Treatment.—Aperients, with diffusible stimulants, especially ammonia, arnica, and valerian; stimulating gargles, *masticatories* of pellitory, &c. If the meatus is dry, and altogether deficient in cerumen, great benefit may be derived from the introduction of a few drops of fish-oil, or of ox-gall, into the meatus, and the application of mustard, and other counter-irritants behind the ear. *Electricity* may be mischievous.

X. ORGANIC NERVOUS DEAFNESS.—Deafness may be caused by *blows on the head*, or fracture, which produces either concussion or rupture of the auditory nerve. Depletion, if any inflammatory symptoms are present, with alteratives and counter-irritants afterwards, are the only remedies.

Deafness may also be produced by *organic alterations in the brain*, and may be attended with epilepsy or idiocy, or may be a consequence of apoplexy or convulsions. The *treatment* must be the same as for amaurosis arising from similar causes (p. 445).*

* Copland, Dict., art., Ear; Pilcher on the Structure and Diseases of the Ear, Lond., 1838; Essay on the Ear, by Joseph Williams, M.D., Lond., 1840; Harvey on Deafness and Enlargement of the Tonsils, Lond., 1850; Toynbee, in Med. Chir. Trans., vol. xxiv.; Med. Gaz., 7th July, 1843; on Senile Deafness, Edin. Monthly Journ. of Med. Sc., Feb. 1849; On an Artificial Membrana Tympani, Lond. 1853; On the Diseases of the Ear, 1860; Yearsley on the Application of Cotton, &c., Lancet for 1848, vol. ii., pp. 10, 64, &c.; Sir W. R. Wilde, Practical Obs. on Aural Surgery, Lond., 1853; Hinton, Diseases of the Ear, in Holmes' System of Surgery, vol. iii. p. 134.

CHAPTER XIV.

DISEASES AND INJURIES OF THE FACE AND NOSE.

SECTION I.—AFFECTIONS OF THE OUTER PARTS OF THE FACE, NOSE, AND LIPS.

I. SALIVARY FISTULA is said to exist when the *stenonian* duct has been perforated by a wound or ulcer, so that the saliva dribbles out on the cheek.

Treatment.—In the first place, a good passage must be established from the duct into the mouth. This may be done by puncturing the mouth through the fistula in two places, passing a small skein of silk, or, still better, a piece of very flexible wire, through the apertures, and securing the two ends in the mouth by a knot. After a few days, when a sufficient aperture into the mouth has been established, means must be employed for closing the fistula. Its edges may be pared and brought together in a straight line, by means of needles and the twisted suture. To facilitate this, the skin may, in some cases, be dissected up, so that it may be shifted along. In some cases, the cautery, a small blunt one, at a black heat, may be passed round the edges, to make them contract. In cases of deep narrow fistula, Marhall's galvanic cautery may be used. In other cases, the aperture may be covered with a flap of skin raised from the adjoining parts.

II. HYPERTROPHY.—The nose sometimes becomes prodigiously enlarged through an hypertrophy of the areolar tissue and skin, especially in persons who have been addicted to the pleasures of the table. Such tumours are very inconvenient and unsightly, but not dangerous. They grow slowly—are indolent and painless—the sebaceous follicles are much enlarged, and secrete profusely, and the skin is more or less mottled with veins.

Treatment.—If the patient desire it, the tumour may be removed with the knife; but the surgeon must first well examine his general health, and put him on regular diet. An incision may be made in the median line nearly down to the cartilage. Then an assistant distends the nostril with his forefinger, whilst the surgeon seizes the morbid growth, and shaves it clean off, close to the cartilage. After the operation, there will be considerable hæmorrhage from numerous vessels. Some of these may be tied, some may be pinched with a forceps, some may be secured with a very fine cambric needle and thread; and any general oozing may be restrained by the application of cold water or matico leaf, or, if it be obstinate, by plugging the nostrils, and making pressure with strips of plaster.

III. RHINO-PLASTIC, or TALIACOTIAN OPERATIONS.—When a portion or the whole of the nose has been destroyed by disease or accident, the deficiency may be restored by a transplantation of skin from an

adjoining part; the operation being varied according to the extent of the deformity. But whether this mutilation arise from scrofulous ulceration, or from lupus, or from scrofulous disease of the bones, or from syphilitic disease, plenty of time should be allowed before any operation is thought of, else it may be frustrated by a return of the disease.

1. When the *whole or greater part of the nose* has perished, a triangular piece of leather should be cut into the shape which the nose formerly presented, and be spread out flat on the forehead, with its base uppermost, and its boundaries should be marked out on the skin with ink. Then the remains of the old nose (if any) are to be pared, and the margins of the nasal aperture are to be cut into deep narrow grooves. When the bleeding from these wounds has ceased, the flap of skin marked out on the forehead is to be dissected up, and all the cellular tissue down to the periosteum with it, so that it may hang attached, merely by a narrow strip of skin between the eyebrows. When all bleeding has ceased, the flap is to be twisted on itself, and its edges are to be fitted into the grooves made for their reception, and to be fastened with sutures. The nose thus made is to be supported, but not stuffed, with oiled lint; it should be wrapped in flannel to support its temperature, and if it become black and turgid, owing to a deficiency in the return of blood from it, a leech may be applied. When adhesion has thoroughly taken place, the twisted strip of skin, by which its connexion with the forehead was maintained, may be cut through, or a little strip may be cut out of it, so that it may be laid down smoothly.

2. The *septum* or *columna nasi* is often restored by the same operation with the nose itself, by means of a flap from the forehead; but it is better, as Mr. Liston proposed, to form it out of the upper lip at a subsequent operation. A strip is cut out of the centre of the upper lip, a quarter of an inch in breadth, and of its whole thickness. The frænulum having been divided, this strip is turned up, but not twisted; and its labial surface having been pared off, and the inside of the apex having been made raw, the two latter surfaces are united by the twisted suture, and the wound of the lip is also united by the same. During the cure, the nostrils must be kept of their proper size by introducing silver tubes occasionally.

3. When *one ala nasi alone* is destroyed, a portion of integument may be measured out on the cheek, and be raised to supply the deficiency. But if both alæ are lost, or if the cheek be spare and thin, it is better to supply their place with skin brought from the forehead. The slip which connects the engrafted portion with the forehead will of course be long and thin; and in order to maintain its vitality, a groove may be made to receive it on the dorsum of the nose. But when union has occurred, this connecting slip may be raised and cut off, and the groove which contained it be united by sutures.

4. *Depression of the apex* of the nose is to be remedied by raising the parts, dividing any adhesions that may have formed, making, if necessary, a new *columna*, in the manner described above, and support-

ing the parts carefully with plugs of lint, till they have acquired firmness. But it may be done still more completely by a method which was proposed by Dieffenbach, and a modification of which has been practised with great success by Mr. W. Fergusson. "The point of a small scalpel," says Mr. Fergusson, "was introduced under the apex, and the ala were separated from the parts underneath; next the knife was carried on each side between the skin and the bones, as far as the infraorbital foramen, taking care not to interfere with the nerves, when, by passing the point of my finger below the nose, I caused the latter organ to be as prominent as could be wished. I now passed a couple of long silver needles, which had been prepared for the purpose, with round heads and steel points, across from one cheek to the other, having previously applied on each side a small piece of sole leather, perforated with holes at a proper distance; then I cut off the steel points, and with tweezers so twisted at the end of each needle, as to cause the cheeks to come close to each other, and thus to render the nose prominent. Thus, by bringing the cheeks more into the mesial line, a new foundation, as it were, was given to the organ. Adhesion occurred in some places, granulations in others; in the lapse of ten days the needles were withdrawn, and in the course of a few weeks, when cicatrization was complete, the nose presented as favourable an appearance as could reasonably have been desired."*

5. *Depression of the ridge*, owing to the loss of the ossa nasi, may be remedied by paring the surface, and covering it with a flap of skin from the forehead; or by making a longitudinal incision, and engrafting a small portion of skin from the forehead into it; or, if the case is slight, by cutting out one or two *transverse* slips, and bringing the cut edges together by sutures, so that thus the surface may be stretched to its proper level.

IV. HARE-LIP signifies a congenital fissure of the upper lip, arising from arrest of development. Its usual place is just on the left side of the middle line; and it may exist on one side only, or there may be a double fissure with a small flap of skin between. With the imperfect development of the skin there is usually more or less of the same condition in the bone. That part of each superior maxillary bone which contains the incisor teeth, and which constitutes a distinct bone in the human embryo, and in many animals—the intermaxillary, or premaxillary of Owen—the divided hæmal spine of the nasal vertebra—may be disconnected on one or both sides, leaving a gap in the alveolus, which may possibly extend backwards, and be complicated with fissure of the palate. This intermediate portion may be displaced and attached like a snout to

* Practical Surgery, 3rd edit., p. 578.

the end of the septum narium. Sometimes the upper incisor teeth and their alveoli project through the fissure in the lip.

Treatment.—The first consideration is the age at which treatment shall be undertaken. Sir A. Cooper used to recommend that it should be put off till the child was two years old, and had cut some teeth, because of the supposed liability of young infants to be carried off by convulsions; but Mr. Fergusson and most modern surgeons believe the risk to be overrated, and prefer operating as soon as possible. Mr. Henry Smith has operated on the fourth day, and Mr. Bateman, of Islington, on the fourth hour after birth with success. Infants may die (just as little Jews die sometimes after circumcision), but such an event is especially rare.

The second point to be considered is, how to deal with the bone, should it project through the fissure. The old plan was to cut it off; but conservatism has gained the day here, as in most other departments of medicine, and at present the plan proposed by Gensoul, and improved by Haynes Walton, is adopted, of cutting perpendicularly through the alveolus with bone forceps between the incisor teeth, and gently bending back the projecting part to a convenient level. In some cases related in Cooper's Dictionary, this object was gained by the use of a truss worn for several hours daily; but if the operation is performed soon after birth, there will be no time for this.

The next step is one recommended by Mr. Walton; and consists in freely detaching the lip from the bones behind, so that it may hang loosely, and be brought together easily.

Fourthly, the edges of the fissure are to be pared. We take it for granted that the child has been quieted by chloroform, and that it is laid flat on the lap of a nurse, with its head on the knees of the surgeon, who sits in front. Then the bone having been bent back if necessary, and the lip freed as just described, the surgeon, seizing the lip by the corner of the fissure with his left forefinger and thumb, pierces it with a narrow knife at the top of the fissure just under the nose, and carries the instrument downwards, so as to shave off the edge of the fissure; and it is better to remove too much than too little. There is a nice manœuvre that should be adopted in finishing the incision. The knife should not be carried straight down, but should be carried inwards, in the direction shown in the cut, so as to save the very bottom of the cleft; by this means, when the parts are healed, there will be less of a notch left. This process is repeated on the other side, and the two strips are next detached from the upper angle. The edges of the fissure being thus made raw, the next step is to bring them into the nicest adaptation possible, and to keep them so. The usual method employed is the *twisted suture*. Three fine lancet-pointed needles are thrust through the raw edges of the fissure. They

should go through about two-thirds of the thickness of the lip. The first should be put through the lower angles, where it is most essential that the adaptation should be most exact; another may run through and compress any artery that bleeds; a third higher up. Then the centre of a long slip of lint, or of twine, should be wound round the uppermost pin and be brought round the others as shown in the chapter on Incised Wounds; besides which, Mr. Fergusson cements the suture and lip by a plentiful application of collodion.

In order to prevent any strain on the stitches, it is now usual to put on a spring truss invented by Dr. Dewar, of Aberdeen, and so contrived as gently to press the cheeks towards the middle line. This is worn till adhesion is firmly established.

The diet of the patient, if an infant, will give no trouble. If he be older, it should be nutritious. There need be no hurry in withdrawing the pins; the fifth or seventh day will be soon enough; and then the cicatrix should be supported by plaster.

If union should fail, the pins or some other suture should be inserted again, to take the chance of union during the granulation stage.

Instead of the twisted suture, some surgeons trust to the common interrupted suture. The *button* suture, represented in the adjoining cut, is warmly recommended by Dr. Wood, now of Barnwood House, Gloucester, who has very successfully cultivated this branch of plastic surgery. He uses on each side two perforated silver discs, having wires soldered to their backs, over which a double ligature is tied, after having been passed through the lip. Mr. Wood believes that by thus avoiding the pinching and rigidity of the needles, he obtains a more efficient and unobjectionable mode of union; and recommends the same suture in cases of divided perinæum and similar cases.†

If the hare-lip is double, both sides may be operated on at once, the middle flap being transfixed by the sutures. But care should be taken to push up the middle flap towards the nose, so as to render the latter organ more prominent, as it is in general very flat in cases of hare-lip.

V. Cancer of the Lip is a very rare disease, and, according to Lebert, more commonly attacks the upper than the lower lip. What is popularly called *cancer of the lip* is in reality—

VI. Epithelioma, of which disorder the lower lip is the favourite seat. Epithelioma, the so-called cancer, or epithelial cancer of the lip, is a disease of middle, or *paulo-post*-middle life, and affects the lower rather than the higher classes, men much more often than women, and

* Dr. Wood's buttons—natural size.

† See paper by Dr. Wood, in Med. Gaz., 1841; Haynes Walton, Med. Times, June, 1848; Fergusson, op. cit.

the left more often than the right side. There must be some sort of predisposition; but the first attack can very often be traced to some slight but incessantly renewed irritation, and especially smoking short earthen tobacco-pipes. Teeth encrusted with tartar, and the habit of holding rough twine between the lips, have been alleged as causes in particular cases. The disease begins as a crack or excoriation, covered with thick epidermis; or as a wart; or as a superficial hardness of the skin; and it usually begins on the red *prolabium*, or on the edge where this joins the skin. In its earliest stage it may continue, for a very long time, stationary or slowly progressing; most likely repeatedly shedding flakes of epidermis, and silently increasing in breadth and depth. At last, however, possibly from some irritating local application, a stage of active progress sets in, and is accompanied by corroding ulceration; and then comes a foul ulcer with hardened base, fungous wart-like edges, and surface covered with scabs of dried pus and epithelium, or exuding a fetid sanious discharge. If it proceeds unchecked, the lip is destroyed; the saliva dribbles from the mouth; the glands under the jaw swell; the muscles and lower jaw-bone are attacked by ulceration and caries; the teeth drop out. The health, sound at first, begins to give way; and the influence of this intense local irritation, combined with the difficulty of taking food, and the absorption of fetid secretions, are amply sufficient to destroy life.

This disease, as to its nature, is probably in great measure local, and destroys life by its local progress, not by general diffusion over the system, as cancer. Its morbid anatomy has already been amply detailed; suffice it to repeat that the dermis, the enlarged papillæ, muscles, glands, and bone are abundantly infiltrated with scaly epithelium; and Paget relates that in two out of seven autopsies, epithelial deposits were found in the heart or lungs. The only wonder, considering how abundant the epithelial nuclei are in the neighbourhood of the diseased part, is, that this is not universal. The diagnosis is generally easy; yet in the earlier stages it might be difficult to distinguish it from any other ulcers caused by irritation and disorder of the health. Mr. Earle showed that all the appearances of cancerous disease might be assumed by common ulcers near the outlets of the body, if subjected to much irritation, but that such ulcers admit of cure by removing foul teeth and other sources of mischief, and attending to the general health. The presence or not of enlarged cutaneous papillæ may serve as a diagnostic mark.

Treatment.—Extirpation, free and early, is the only remedy worth speaking of; and the surgeon's chief anxiety should be to remove all the affected tissues, without regarding the patient's appearance. The

classical V incision, as Lebert terms it, may therefore be abandoned; and a clean sweep made with the knife. The wound must be brought together vertically by pins and the twisted suture; and, if desirable, in order to facilitate this, incisions may be made at each corner of the mouth. The operation may be successful; at all events the cure may last the patient's life; but quite as often, or more so, a relapse occurs within the space of from six months to two years. The more quickly the disease has relapsed, the more quickly it is likely to do so, after a second operation; yet the operation should be boldly repeated, and the glands or jaw-bone be removed, if necessary. Hannover relates the case of a man who was operated on for the first time in May 1834, for a disease of two years' duration; the second time in 1846; the third in 1849; the fourth in 1850; with good results up to 1852. No instance is known of a spontaneous cure of *ulcerated* epithelioma of the lower lip; and the knife, under chloroform, is infinitely less formidable than the daily miseries of the disease. In cases not fit for the knife, the palliative treatment of cancer must be adopted.*

VII. Corroding Ulcer of the Face; Lupus Exedens; Cancroid.—Epithelioma proves fatal, as we have just narrated, by the supervention of a corroding and intractable ulceration in a tissue previously infiltrated with epithelium. But we must recall to the student's memory, that a corroding ulcer, proving ultimately fatal, is apt to attack the face, without pre-existing epithelial, or cancerous disease. Lupus exedens is an instance. Another, closely allied, is a sort of corroding ulcer, which is very apt to affect the lower eyelid, nose, or cheek of the aged. It often affects some wart that has existed for years. It produces an irregular dryish glassy ulcer, without the hard base or warty edges of epithelioma, or of hard cancer; and so slowly progressive that it may sometimes be doubted whether the patient has died of the disease or of old age. The glands are not affected. Excision of such ulcer, or of its precursory wart, may be performed; but these are the cases in which a permanent cure may be hoped for by the use of arsenic as a caustic. The case of the late Pope, Gregory the Sixteenth, may be an example. He had a corroding ulcer on the nose, which was treated successfully with the arsenical paste, by M. Allertz, of Aix-la-Chapelle, so that the ulcer healed, and there was no relapse during the remaining eight years of the Pope's life. True epithelioma and cutaneous cancer may also affect the face, head, or ear; but it seems that in none of these parts is epithelioma so rapid in its progress, or so likely to relapse after operation as in the lower lip.

VIII. Cancrum Oris—(*Phagedæna oris, gangrenous erosion of the cheek*)—is a phagedæno-gangrenous affection of the lips and cheeks, occurring almost exclusively amongst the ill-fed squalid children of large towns. It appears to be a disease of debility, and to be induced by want of proper food and of fresh air, and by neglect of cleanliness. Like other disorders of a similar character, it is very liable

* See Paget, Lectures, vol. ii.; Lebert, op. cit.; Hannover, op. cit.

to follow the measles or scarlatina, or any other severe and weakening illness.

Symptoms.—In the instances which have fallen under the author's observation, it has commenced as a shallow ulcer on the lip or inside of the cheek: with a peculiar dirty-gray or ash-coloured surface, and black edges. Sometimes it is said to commence with an exudation of a pale-yellow fibrinous matter, like that exuded in diphtherite. At the same time the face is swollen, the breath exceedingly fetid, and there is a dribbling of fetid saliva mixed with blood. If the disease proceeds, the ulcer becomes gangrenous, and destroys the cheek and gums; the teeth drop out, typhoid symptoms supervene, and the patient dies exhausted. The swelling which accompanies this disease shows nothing like active or healthy inflammation. It is moderately firm, or what may be called semi-œdematous, and is either pale, or else of faint-pink colour. In the most rapid form of the disease it commences at once as a black spot of gangrene, which slowly spreads, and is not accompanied by any inflammation whatever; all the parts around being quite pale and wax-like. The constitutional symptoms are at first those of weakness, and disorder of the stomach and bowels, and afterwards the rapid feeble pulse and stupor of typhus.

Diagnosis.—The diagnosis of this affection is of some importance, because when a child has died of it, the parents, through ignorance or malice, are liable to bring the surgeon into trouble, by accusing him of having caused death through profuse mercurial salivation. The chief points of distinction are, that in this disease the ulceration or gangrene is *circumscribed*, and is generally confined to one side; and that it commences usually in the cheek, and that it only affects that part of the gums which is in close contiguity, and that the tongue is untouched. Whereas in severe mercurial salivation, the ulceration is diffused; the whole of the gums, and the lining membrane of the cheeks, and the tongue, as well as the palate, being affected from the first.

Treatment.—The indications are threefold. 1st. To evacuate and correct the secretions of the stomach and bowels by a dose of calomel, followed by rhubarb and magnesia. 2ndly. To keep up the strength by wine, beef-tea, and other nutritious articles, and by bark or quinine in sufficient doses. The *chlorate of potassa* has been strongly recommended, and may be given in doses of gr. xx,—xl. in the twenty-four hours. 3rd. To excite a healthy action in the diseased part by stimulating lotions, especially solution of nitrate of silver, alum, sulphate of copper, or the chloride of lime; and, lastly, if these means fail to arrest the disease, by applying the strong nitric acid so as to destroy the whole of the diseased part, in the same manner as was directed for hospital gangrene.*

IX. CHEILO-PLASTIC OPERATIONS, by which are signified operations for the restoration of the lip, may be expedient when the lower

* See James on Inflammation, p. 527; Marshall Hall, in Lancet for 1839—40, p. 409; P. H. Green, ibid.; and also in Cycl. Pract. Surg., art., Cancrum Oris; Willis on Cutaneous Diseases; Hunt, Med. Chir. Trans., vol. xxvi.

lip has been so destroyed by cancrum oris, or by ulceration, or operation, as to occasion deformity, and difficulty of speaking, or of retaining the saliva. Such operations may consist in bringing soft parts from the sides of the face towards the middle line, and retaining them by a twisted suture, as in hare-lip; but the exact incisions required must depend on the circumstances of the case, which may vary *ad infinitum*. In other cases, sufficient substance to form a new lip may be raised from below, by making a curved incision from one masseter to the other below the chin. A vertical incision downwards in the middle line will allow a considerable flap to be raised on each side to the proper level to form a new under lip. The incision in the middle line must now be stitched together, and the new lip must be kept up to its proper place, and prevented from being again drawn down, by stitching its lower margin to the periosteum of the jaw. This plan was proposed by Dr. Hamilton, U. S. Operations may also be required for enlarging the mouth when too small; in which case, after sufficient incision, the cut edges of the skin and mucous membrane should be united by sutures, so that they may heal over (see Phymosis). In a case of this sort, Mr. Hancock, before making his incision, ascertained, by desiring his patient to grin, the exact insertion of the levators of the angles of the mouth, and carried his incisions to this spot. For contracting the mouth, if too large, or if one corner of it is rendered flabby and unmanageable by palsy of the portio dura, Mr. Hilton has cut a piece from one corner.*

SECTION II.—AFFECTIONS OF THE NASAL CAVITIES.

I. FOREIGN BODIES may be removed from the nose by a small curette, or scoop, or bent probe. If they cannot be brought through the nostrils, they may be pushed back into the throat. The removal should be effected as early as possible.

II. EPISTAXIS, or *hæmorrhage from the nose*, may, like other hæmorrhages, be produced, 1st, by injury; 2ndly, it may be an *active* hæmorrhage of arterial blood caused by general excitement and plethora, or by determination of blood to the head, or by the suppression of some other discharge, or by one of those forms of irritation of mucous membrane, common in the scrofulous and phthisical; 3rdly, it may be a passive draining of venous blood, owing to obstruction of the circulation by disease of the heart or liver, or to a morbidly-thin state of the blood, together with relaxation of the vessels, as happens in scurvy, purpura, and the last stage of fever.

Treatment.—1. If the patient be red-faced, plethoric, and subject to headache and giddiness, the hæmorrhage may be regarded as a salutary

* See the surgical works of Fergusson, Syme, Pancoast, and Jobert de Lamballe; Hilton's Clinical Lectures, Lancet, 1853, vol. I.; Case of Restoration of Lip, by Dr. F. H. Hamilton, of the United States; Ranking, vol. xvi.; Mr. Hancock's case, Lancet, 10th Sept., 1853. By the way, it is much to be desired that plain English be used instead of dog Greek. To speak of a Rhinoplastic operation on the lip is ridiculous; and reminds one of the French phrases *bifteck de veau*, and *rosbif de mouton*.

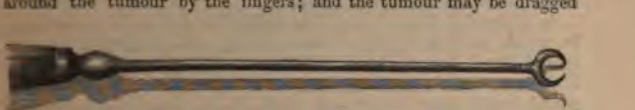
effort of nature; a good purgative, F. 33, should be administered, the liver, bowels, and kidneys be thoroughly cleared, and the diet regulated; if the bleeding continues, the sulphuric acid, F. 24, may be given, to which sulphate of magnesia may be added if the bowels require it, and quinine or steel under other circumstances. 2. But the hæmorrhage requires to be stopped at once, either if it have continued so long that the patient will be injuriously weakened,—or if it arise from injury,—or if it be a *passive* hæmorrhage depending on visceral disease or general cachexy. If an upright posture, a bladder of ice applied to the forehead or a piece of cold metal to the back, with a draught of iced water or lemonade, and compression of the nostril, do not stop it, the patient may snuff up powdered gum, or gall-nuts, or powdered *matico*; and, these failing, the nostrils must be gently plugged with lint. In very urgent cases, the posterior orifice of the nostril must be plugged also. This is easily done by passing a bougie, with a long piece of silk fastened to its end, through the nostril into the pharynx. The end of the silk in the pharynx is then brought through the mouth with a pair of forceps, and a piece of soft sponge, less than an inch in diameter, is tied to it. Then by pulling the silk back through the nose, the sponge is drawn into the posterior opening of the nostril. The plugs of coagula, in severe cases, should not be disturbed for three days.

Local treatment being provided for, the case must be treated constitutionally. If there is great fever and vascular excitement, the nitrate of potash, F. 58, or tartar emetic, F. 68, may be of use; in cases in which the liver is deranged, the nitromuriatic acid and dandelion, F. 22; in cases in which the blood seems deficient in coagulability, alum, F. 187, sesquichloride of iron, gallic acid, F. 186, or turpentine, F. 74.

III. NASAL POLYPUS.—1. The common *gelatinous* polypus is a tumour of the consistence of jelly, pear-shaped, yellowish, slightly streaked with blood-vessels, attached by a narrow neck to the mucous membrane. The patient has a constant feeling of *stuffing* and cold in

the head, which is increased in damp weather. If he force his breath strongly through the affected nostril, whilst he closes the other, the polypus may be brought into view. There are very often more than one of these tumours, and they are very liable to return when removed. If polypus be permitted to remain, it continually increases in size, blocks up the nostril, displaces the septum, and obstructs the other nostril, causes prodigious deformity of the cheek, prevents the passage of the tears, and may even cause death by pressure on the brain. The structure of these polypi is fibro-cellular or areolar tissue, covered with ciliated epithelium. The most usual point of attachment is one of the superior turbinated bones.

Treatment.—A probe should be introduced to feel for the neck of the polypus, which should then be seized with forceps, and be gently twisted off. If, as sometimes happens, it projects backwards into the pharynx, it must be extracted through the mouth with curved forceps if requisite, or a loop of stout twine may be passed, by means of a bougie, along the floor of the nostril into the pharynx, where it may be passed around the tumour by the fingers; and the tumour may be dragged



forwards through the nostril. The double hook depicted here may be stuck into a polypus, and twisted round and round so as to tear it off. Such hooks are made by Savigny, of various sizes, for polypi of the ear, nose, and uterus. Wilde's snare for polypus of the ear, depicted at p. 456, may be useful. Formerly surgeons used to strangulate these tumours by passing the ends of the ligature through a double canula, in the same way in which it was customary to treat uterine polypi. But clean evulsion is a far preferable operation, and there is no fear of any bleeding that cannot be checked by iced water or by plugging. In a few cases it may be necessary to slit up the ala of the nostril where it joins the cheek, in order to get at the root of the tumour.

Polypus, it must be observed, is a coarse old-fashioned word employed to signify any sort of pedunculated tumour attached to a surface, to which it was supposed to adhere like a parasite with many claws. Thus fibrinous clots attached to the interior of the heart used to be spoken of as polypi of the heart. But the most frequent seat of polypi is mucous membrane; and the most common and legitimate species is that *fibro-cellular* tumour, developed in the submucous tissue, and covered with entire mucous membrane, which we have just described. 2. Another variety is composed of *fibro-plastic* cells, and is, in fact, a mass of granulations, not developed into fibro-cellular tissue. This is, unlike the preceding, often caused by local irritation. The common aural polypus is an example. 3. Warty and epithelial growths with narrow necks constitute another variety. 4. Lastly,

cancer, encysted tumours, or any other sort of tumour which projects and has a narrow neck, may be called by the same name. For instance, The *hydatid* polypus, a rare variety, described by Sir A. Cooper as consisting of a number of thin vesicles filled with a watery fluid, and attached by a peduncle, bursting upon the slightest pressure. Sir A. Cooper recommended that the peduncle should be touched with a hair-pencil dipped in butter of antimony.

IV. CANCEROUS TUMOURS, projecting into the nasal cavities from the antrum or the adjoining parts, have been described as *fungoid* or *carcinomatous* polypi. Rapidity of growth, a bleeding fungating surface, and pain and signs of cachexia, will probably be diagnostic marks sufficient to deter the surgeon from attempting evulsion with forceps. It must be remembered that soft cancer originating within the cranium may come down through the ethmoid into the nose.

V. RHINORRHŒA, or OZÆNA, so called from its fœtor, signifies a purulent or sanious discharge from one or both nostrils. Like otorrhœa, it is but a symptom, and it will be necessary to consider the morbid conditions on which it may depend.

1. *Catarrhal Rhinorrhœa.*—The writer has seen very many cases, in which patients of delicate constitution, after a tedious common catarrh, have been troubled with most profuse and obstinate purulent discharge from the nasal cavities, often very fetid in the morning; attended with great weight and stuffing in the head, copious flow of tears, frontal headache, relaxed throat, cough, and general signs of debility; but more especially great depression of spirits. Sometimes, under such circumstances, the mucous membrane swells into red fleshy eminences. In a case in which the writer was consulted this year, a portion of the swelled mucous membrane had been mistaken for polypus, and it had been proposed to extract it. This state of things is often accompanied with catarrhal deafness. The *treatment* is easy, and includes removal to a dry bracing atmosphere, aperients, bark with mineral acid, and the inhalation every evening of the steam of boiling water, to which twenty or thirty drops of creosote have been added. For the mode of inhaling, see Chap. XV.

2. *Scrofulous Rhinorrhœa* generally begins early in life, and depends on inflammation or ulceration of the mucous membrane. It may be a consequence of the catarrhal variety, or may follow some fever, or may begin spontaneously. The discharge is more fetid in itself; and not only so, but it is mixed with exudation, and collects in the upper part of the nasal cavities, and there putrefies, giving rise to an odour that causes the patient to be a nuisance to all about him. If the case goes on from bad to worse, the bones may be implicated; either the septum may be eaten through, which is of little consequence, or the nose may sink in, and the same hideous deformity may ensue that was formerly not uncommon in secondary syphilis. *Treatment.*—The writer has often been surprised at the inefficient treatment pursued in these cases; in which, although there is no danger to life, yet the nauseous effluvium that issues from the patient renders him a pest to himself and all

m. He some time since treated a highly-respectable female, l long been afflicted in this way, and had been cruelly salivated mist, and excoriated with a nitrate of silver injection, with he had been supplied at an hospital. The relief afforded by a ringe daily used so as to wash away all clots and collections of with a copious stream of warm water, to which a little chloride F. 127, 136, may be added, is unspeakable. A leech or two e applied to the inside of the nostril if the bridge of the nose is or if there are any marks of obstruction about the lachrymal The citrine ointment, F. 168, may be thoroughly applied by a hair brush, and bark, iodide of potassium, cod-liver oil, and ti-scrofulous remedies be administered in tedious cases.*

yphilitic Ozæna requires no further remarks; but we must add ne cases of the apparently scrofulous variety, in children, may ir origin in congenital syphilis. The presence of *foreign bodies* always be inquired into in any case of discharge from the

MPERFORATE NOSTRILS.—The nostrils are sometimes *imper-* owing to congenital malformation. The passage may (if the wish it) be restored by a cautious incision, and must be kept th bougies. If, however, the obstruction be seated far back it ot to be meddled with.

CTION III.—AFFECTIONS OF THE ANTRUM AND JAWS.

BSCESS OF THE ANTRUM may be caused by blows on the ut it more frequently results from the irritation of decayed It has been caused in a newly-born infant from injuries received parturition; the face having presented to the pubes.† The ns are permanent aching and uneasiness of the cheek, preceded by acute throbbing pain and fever and rigors, and followed, ming is not made soon, by a slow general enlargement. This, tted to increase, causes bulging of the cheek, extrusion of the truction of the lachrymal duct, depression of the hard palate, g and dropping out of the teeth, and closure of the nostril. ietes of the cavity sometimes become so thin from distension, y crackle on pressure like parchment. Sometimes (though the matter makes its way into the nostril; and sometimes the oints externally, or bursts into the mouth.

ment.—A free aperture may be made into the cavity. If the molar teeth be loose or carious, it should be extracted, rocar be pushed through the empty socket into the antrum. all the teeth are sound, or if they have been all extracted n incision should be made through the membrane of the mouth e alveoli of the molar teeth, and the bone be pierced by a strong

* Paper by R. Druitt, for further details of the Treatment of Ozæna, ies, 1858, vol. ii., p. 417.
† Rees, Med. Gaz., N. S., vol. iv., p. 860.

pair of scissors or trocar, as represented by the following figure. The instruments should not be made of too highly-tempered steel, lest they break. The cavity should be frequently syringed with warm water, in order to clear away the matter, which is sometimes thick like putty. If the discharge continues profuse and fetid, search should be made with a probe for loose pieces of bone, which should be removed without delay, the aperture being enlarged if necessary.

II. DROPSY OF THE ANTRUM.—The antrum may become enormously distended, in consequence of an accumulation of its natural clear mucous secretion, if the aperture into the nostril has become obliterated. In a case which occurred in Mr. Fergusson's practice in the King's College Hospital in 1850, there was great protrusion of the cheek, and of the hard palate, and other signs of tumour, so that the patient was sent up for the purpose of having the bone extirpated; but on examination it was discovered that the antrum was greatly distended with a yellow viscid fluid containing brilliant particles of cholesterine; and an opening having been established through the anterior wall of

the cavity, the patient was soon discharged cured.* In some cases the parietes are so thin as to crackle on pressure.

III. TUMOURS OF THE UPPER JAW-BONE may present themselves in very great variety. Thus, in addition to the abscess and dropsy of the antrum, there may be—

1. *Hypertrophy of the bone*, some part of which increases immensely in bulk without forming a circumscribed tumour.

2. *Exostosis*; a circumscribed tumour of bony tissue, porous, or hard and dense as ivory.

3. *Enchondroma*; which is rare.

4. *The Fibro-plastic tumours* of Lebert, constituting, as he observes, tumours perhaps of the consistence of firm brain; often blotched with red, and very difficult to distinguish from cancer, except by microscopic examination. A specimen which the author recently saw extirpated by Professor Fergusson, and which had returned after a previous operation, was of the colour and consistence of kidney, and afforded most brilliant examples of large many-nucleated mother-cells.—See *Fibro-plastic Tumours*.

5. *Fibrous tumours* (*Osteo-sarcoma*); dense and homogeneous; containing bony spicula.

6. *Encysted tumours*; which, when situated within, or in front of the bone, have doubtless been more than once mistaken for enlarged antrum. Such tumours may contain glairy matter, and not seldom teeth, and probably consist of tooth capsules, unnaturally developed.

7. *Cancer* affects the upper jaw more frequently than it does any other bone, and constituted 10·35 cases of cancer of the bones collected by Lebert.

The *symptoms* of any one of these growths—which may be developed in the gums, periosteum, alveoli of the teeth, or in the cancellous substance of the bone, or in the antrum—are manifested by a tumour bulging the cheek in front; which may increase, depress the roof of the mouth, and loosen the teeth; protrude into the nostril, and beneath the base of the skull into the pharynx; lift up the floor of the orbit and displace or compress the eye; and so, if allowed to remain, may render life odious by deformity, and at last put an end to it by interfering with breathing, or swallowing, or by compressing the brain.

The *diagnosis*, which is important, is between the growths of local character, which if thoroughly extirpated, do not return, and cancer. Slowness of growth; freedom from pain; an equable and firm consistence of the swelling; the skin moveable over it; ulceration of any projecting part within the mouth, if it exists, superficial, not fungating nor bleeding, nor yielding a copious, thin, fetid discharge; the tumour not affecting the general health, otherwise than by the inconvenience necessarily attached to its situation and bulk—these are the indications of a fibrous, or other non-cancerous growth. On the contrary, rapid growth, early cachexia, grinding pain, early loss of teeth, bleeding fungous growths projecting from their sockets, or into the nose or

* Med. Times, 18th May, 1850.

pharynx (where they may be felt by passing the fingers up behind the velum pendulum), and implication and adhesion of neighbouring parts, give the best grounds for pronouncing the growth cancerous.

Treatment.—For all these tumours, excepting decided and rapidly-growing cancers, extirpation as early as possible is the remedy. In cases of cysts, however, attached to the front of the bone, it suffices to lay them freely open, by removing their anterior wall.

The student who desires to understand, and the surgeon who proposes to execute, this operation, may naturally divide it into two parts; first, the incisions through the soft parts necessary for laying bare the tumour; and, secondly, the division of those processes of bone necessary for detaching it afterwards. The great experience of Mr. Fergusson has enabled him very materially to abridge the incisions through the soft parts. In the case of a very small tumour, it may be perfectly possible to remove it through the mouth; but if this opening be insufficient, Mr. Fergusson cuts through the upper lip exactly in the middle line, and carries the incision into the nostril. By thus availing himself of the natural expansion of the nostrils, he gains as much room as by a much larger incision from the angle of the mouth, and there is less bleeding at the time, and less deformity afterwards. If, however, the tumour requires more room for its removal, the incision just described must be carried up between the ala of the nose and the cheek, to within half an inch of the eye; probably another from the angle of the mouth to the zygoma; possibly another at right angles to this. After this the operator must dissect up the flap of the cheek, large or small, from the tumour, so as to lay it quite bare; and, in so doing, the infraorbital artery and nerve will probably be divided.

The next step of the operation consists in the division of the various attachments of the tumour, and in removing it. If circumscribed and seated in the front wall of the antrum, it may be sawn round and detached by forceps, without removing the alveoli; otherwise the surgeon begins by extracting an incisor on the one side, and a bicuspid or molar tooth on the other side of it, and by cutting through with his bistoury the gum and mucous membrane covering the bone at the parts where separation is to be effected. Perhaps he may turn the membrane back in flaps, so as to save as much as possible of the soft parts of the roof of the mouth. Then he cuts through the bone with curved bone forceps; or, if necessary, he grooves the bone above and on either side with small saws of various sizes and shapes, sawing quite through the alveolar processes, and completing the separation of the tumour with the cutting bone forceps.

But let us suppose that the tumour is large, and requires the removal of the body of the superior maxillary bone, but not the malar or floor of the orbit. If the student examines a skull, he will see that the bones which require to be divided are these:—viz., first, the horizontal palatine plates of the superior maxillary and palatine bones, with the alveoli corresponding to the incisor teeth. This (after the alveoli are sawn through) may be done with a saw, or by means of

bone forceps, one blade being introduced into the nostrils, the other into the mouth. Secondly, the body of the superior maxilla must be sawed horizontally across just below the orbit, and the severance be completed as before by forceps; and lastly, the tumour must be grasped most firmly with a strong pair of clawed forceps used by Mr. Fergusson (the Lion Forceps), and must be forcibly wrenched from its attachment to the pterygoid plates of the sphenoid; and so it may be removed.

Again, let us suppose that the entire bone is so implicated that the whole of it, including the floor of the orbit, must be extirpated; then, in addition to the division of the hard palate as before, the ascending nasal process must be cut through at the level of the orbit, and the malar bone likewise at its middle. If the malar bone requires to be removed as well, the zygoma, and the process which unites it with the frontal, must be divided. The contents of the orbit must be separated by careful dissection, and be held up with a bent spatula. When the processes of bone just mentioned have been cut through, the tumour must, as before, be forcibly moved, to separate it from the pterygoid and lachrymal bones, and dislodge it; the infraorbital nerve must be gently divided behind; in all cases the soft palate should be left untouched; and an incision carried along in front of it to the last molar tooth, should be made at the beginning of the proceedings. During the operation, the common carotid may be compressed, to prevent hæmorrhage. After it, the facial, and any other arteries that require it, are to be tied, the chasm to be filled with lint, and the wound closed with sutures.*

IV. FISSURE OF THE PALATE.—As the upper lip may be fissured through defective development, so also may the various parts constituting the hard and soft palate. In some cases the uvula merely is fissured; in others, the cleft extends forwards as far as the lips, and may be combined with a hare-lip. The fissure in the hard and soft palates is invariably in the middle line, but when it extends forwards through the alveoli, it diverges somewhat to one side. In a few cases the fissure is double in front, so that it may, as a whole, be compared to the letter Y, the two lines in front having the pre-maxillary bones between them.

This affection, when extensive, necessarily causes very great difficulty

* See Fergusson's Practical Surgery, 3rd edit., p. 678; Liston on Tumours of the Face, Med. Chir. Trans., vol. xx.; Paget's Lectures, vol. ii.; Henry Smith, Med. Times, April 17, 1852; R. G. H. Butcher, Dublin Quarterly Journ. Med. Science, 1853.

in sucking and swallowing, and great risk of losing the child through starvation; if the child grows up, it causes a very serious impediment to distinct articulation.

Treatment.—When the fissure of the palate is combined with hare-lip, and the gap extends from back to front entirely through the hard and soft palate and lip, the lip should be operated upon soon after birth, in the manner described when we spoke of hare-lip; and the observations then made should be attended to, as to the saving and pushing together any projecting bone. During childhood, trusses should be worn to bring the edges of the bony fissure nearer together.

If, however, the fissure at birth should be discovered to be in the soft parts only (as shown in the next cut), the surgeon may adopt M. Cloquet's plan of cauterizing the angle of the fissure for a very limited extent, and allowing it to cicatrize; then repeating the operation again and again till the contraction following each cicatrization has closed the whole fissure. The cautery should be a small iron, at a black heat. M. Cloquet had tried this method upon four patients at the date of the publication of this paper, with success. The author is not aware that it has yet been adopted by any English surgeon, but hopes that this will soon be the case; as it will be a most important boon to patients, if their malady can be relieved during infancy, before they have acquired a defective mode of speaking, and so if they can be spared the misery which this deformity and the usual operation inflict upon them.*—See *Cautery*, in Part v., chap. iii.

The method heretofore adopted has been to leave the patient to attain the age of puberty, and then to perform the operation of *Staphyloraphy*, or suture of the uvula. This is always a difficult, and in former days anything but a successful, operation, owing in great measure to the difficulty of preventing the flaps, when united, from being dragged asunder by the muscles. Mr. W. Fergusson, who for the first time carefully examined and dissected the malformed parts, ascertained exactly what the forces and effects of the muscles really are, as follows:—

It had been often remarked that the action of the muscles upon the edges of the fissures in the soft palate was difficult of explanation. If the deformed part is examined whilst perfectly quiescent, the gap is seen conspicuously, the lateral flaps are distinct, and the posterior nares, with the upper end of the pharynx, are observed above and behind them. If now the flaps are touched, they will in all probability be jerked upwards; and if they be still further irritated, each flap will be still more forcibly drawn upwards and outwards, so as hardly to be distinguishable from the rest of the parts forming the sides of the nostrils and throat. But, on the other hand, if the pharynx be irritated, and made to perform the act of deglutition, the margins of the fissures will be brought together.

Now it is easy to understand that the separation of the flaps must

* See abstract of M. Cloquet's paper in Gaz. Méd., March 3, 1855; Brit. and For. Med. Chir. Rev., July 1855; Ranking, Abstract, vol. xxi.

be produced by the action of the palatine muscles, and also that this must occasion a very serious impediment to any operation for uniting them by adhesion; but the muscular action *by which the flaps are brought together* was a mystery till Mr. Fergusson showed that it was caused by the upper semicircular border of the superior constrictor muscle of the pharynx; and to him is due the credit of proposing that the muscles which tend to separate the flaps should be neatly divided, and of showing what the muscles are, which really need to be divided, viz., the levator palati, and the palato-pharyngeus.

The operation is thus described by Mr. Fergusson:—"With a knife whose blade is somewhat like the point of a lancet, the cutting edge being about a quarter of an inch in extent, and the flat surface being bent semicircularly, I make an incision, about half an inch long, on each side of the posterior nares, a little above and parallel to the palatine flaps, and midway across a line straight downwards from the lower opening of the Eustachian tube, by which I divide the levator palati on both sides, just above its attachment to the palate.† Next I pare the edges of the fissure with a straight, blunt-pointed bistoury, removing little more than the mucous membrane; then, with a pair of long, blunt-pointed, curved scissors, I divide the posterior pillars of the fauces, immediately behind the tonsil, and, if it seems necessary, cut across the anterior pillar too; the wound in each part being about a quarter of an inch in extent. Lastly, stitches are introduced by means of a curved needle set in a handle; and the threads being tied, so as to keep the cut edges of the fissure accurately in contact, the operation is completed."

The patient should be intelligent and quiet; and not under 12 or 14. Iced water for gargling, so as to check the bleeding, should be at hand. The parts must be well dissected from the hard palate, by which means

* From a preparation of Mr. Fergusson's in the King's College Museum.

† "If care be taken, in dividing the levator palati, not to run the knife towards the upper and back part of the pharynx, there is no harm to be dreaded from the incision above described. Were the instrument carried far upwards and backwards, the internal carotid would be in danger; but if its point be pushed straight outwards and forwards, it will sink into the pterygoid fossa, and possibly divide the tensor palati muscle, where it can come in contact with the external pterygoid process only."—Fergusson's Pract. Surg., 3rd edit., p. 612.

all tension will be taken off, and the sides of the fissure will fall loosely together, and the stitches may be now applied. It is *highly important* that a sufficient number of stitches be introduced. The greatest strain will be generally at the anterior extremity of the fissure, where the soft parts are most firmly connected with the bones. The stitches are introduced by means of a curved needle set in a handle. "The point of the instrument, armed with a small smooth thread, is passed from below upwards about a quarter of an inch from the cut margin of the fissure, and made to appear in the middle of the gap, when the thread is seized with forceps, drawn three or four inches out of the mouth, and then the needle is withdrawn. A similar manœuvre is followed on the opposite side." Thus there is a double thread through each side of the fissure. One thread, C, is now pulled through; one end of it put into the loop of the other thread; when, by pulling A B, C will be drawn through the other side. This manœuvre, which is of great use in all plastic operations in deeply-seated parts, is ascribed to Mr. Avery. "Two, three, four, or five threads, of different colours for distinction' sake, are introduced in this way, and then, after the cut margins of the flaps are sponged free of blood and mucus, the various threads are fastened." The knot shown in the next cut is a good way of bringing the edges together; a double-reef knot, not too tight, so as to allow of swelling, will make all secure. After the operation has been finished, the patient must be kept perfectly quiet. It is better that the patient should not take anything for some hours after the operation until the parts have become somewhat quiet; but then bread soaked in milk, or in good beef-tea, which has some pounded meat mixed with it, should be given, so as to supply good plastic material. Enemata of beef-tea may be of service.

The surgeon need not be in any great hurry to remove the stitches. Mr. Fergusson, in his early operations, was in the habit of taking them away on the second day after the operation, but latterly he has permitted them to remain longer. "It is better, in my opinion, to let the threads remain several days too long than that they should be moved a minute too early. Usually I take one or two stitches away on the third or fourth day, and on the fifth or sixth remove them all. It is better, I think, to take them out at intervals than all at once."*

It must be remarked that many surgeons think that the division of the muscles in the above-described manner, does not offer any particular advantages over free lateral incisions, parallel with the edges of the cleft.

* See Fergusson's Practical Surgery, Med. Chir. Trans., vol. xxviii.; Medical Times, Nos. 388 and 389; Lond. Journ. of Medicine, Jan. 1849; and some successful cases by Mr. Gay, Lancet, Feb. 19, 1853.

Fissure in the anterior part of the bony palate may be left, after the fissure in the soft parts behind has been closed. As we have before said, during growth, whilst the bones are pliable, the maxillary bones should be pressed together by means of a truss worn daily for some hours. At puberty, relief may be further attempted by means of an operation first proposed by Dr. J. M. Warren, of Boston (called urano-plastic, from *οὐρανος, a vault*). This consists in paring off the tissues from the bones on each side of the fissure, in two lateral flaps, and stitching these together in the middle line. The late Mr. Avery, whose patience and mechanical ingenuity admirably fitted him for operations of this nature, was very successful in closing fissures in the front of the palate, as the writer had opportunities of witnessing. Mr. Pollock has also operated successfully.*

If no operation can be done successfully, the last resource is an *obturator*, or, in plain English, a plug, of gold or caoutchouc, to close the aperture. But this should not be used during growth, otherwise it will hinder any natural process of recovery; and if too large a plug be used, it will cause absorption of the palate, and make the evil worse.

V. TUMOURS OF THE LOWER JAW may be of any of the varieties which affect the upper jaw, but cancer is not so frequent. Their distinctive characters have been before detailed. Free extirpation is the remedy; and in this, as well as in the case of tumours of the upper jaw, Mr. Fergusson advises the incisions to be carried in such directions as shall cause the least subsequent deformity; and states his belief that any portion, or even the whole of the bone, may be taken away without cutting the margin of the lip; by which means the cicatrix will be less conspicuous, and bleeding from the labial artery will be saved. Mr. Syme adopts the same course. The incisions are carried along, parallel to the horizontal or ascending ramus, and are made so long that the tumour may be thoroughly exposed when the flap is raised. If the tumour is large, and situated near the middle of the bone, it must be laid bare as we have just described. A tooth must be extracted on each side of the tumour: next, the bone may be sawn half through perpendicularly on each side, and then be divided completely by the straight cutting forceps, one blade being passed up on the inner side of the bone, and the other placed in the groove made by the saw; and lastly, the parts attached to the inner side of the bone must be

* Pollock, Med. Chir. Trans., 1856.

cautiously divided; namely, the digastric, mylo-hyoid, genio-hyoid, and genio-hyo-glossus muscles. When the attachments of these muscles are divided, care must be taken not to let the tongue retract into the throat, which might push back the epiglottis and cause suffocation. To prevent this, a ligature may be passed through the tip of the tongue, by which it may be held forwards during the operation, and which may be fastened to the twisted suture by which the wound is afterwards to be closed.

If, however, the disease is not so very extensive, it may not be necessary to sacrifice the whole thickness of the bone, but a horizontal portion of the base of the bone may be saved, which will prevent the chin from falling in after the operation. In order to effect this, the bone may be sawn downwards for half its depth on each side of the tumour, and a horizontal cut be made below it; and then the diseased portion be separated completely with the cutting pliers.

If a lateral portion is to be removed, an incision should be made along the basis of the bone, to its posterior angle, and up behind the ascending ramus. Thus a flap is formed, which may be turned up so as to furnish a good view of the tumour, and then the bone is to be divided as before described.

If the extent of the disease renders it necessary to remove the entire side of the bone, and to separate it from its articulation with the temporal, the operator must begin by making a curved incision from beneath the ear, along the basis of the jaw to the chin. The flap so formed is to be dissected up, and the masseter with it; an incisor tooth is to be removed, and the bone to be sawn vertically through; the end is next seized and depressed, and the temporal muscle dissected from the coronoid process; the pterygoid muscles and other internal attachments are then to be divided, and finally the ligaments of the joint. Whilst effecting the disarticulation of the condyle, the point of the knife should be kept close to the bone, so as to avoid all risk of wounding the external carotid artery. After bleeding has been restrained, the wound is to be closed by sutures, excepting at the middle, where an aperture should be left for the ligatures, and to permit the escape of discharge. The salivary ducts and facial nerve divided in these operations may be left to themselves; the muscular power of the face is usually recovered, and the saliva finds a channel into the mouth.*

VI. NECROSIS of portions of the jaws is occasionally the result of mechanical violence, carious teeth, or violent salivation; but of late years a new source of this disease has been detected in *phosphorus*. This when imbibed by persons employed in lucifer match manufacto-

* See Liston's Elements of Surgery, and Practical Surgery, 2nd edition; Guthrie, in Med. Gaz., vol. xvii.; Brodie, ibid., vol. xv.; Liston on Tumours of the Face in Med. Chir. Trans., vol. xx.; Bell on the Teeth; Jobson on the Teeth; and Fergusson's Practical Surgery. Diseases of the lower jaw requiring amputation have been caused by a projection anteriorly of the coronoid process, which hindered the evolution of the wisdom tooth.—Forbes's Rev., vol. viii.

[illegible] by [illegible] of a portion of the jaw. There is no
ion subsequently as in common necrosis.

tment.—In the earliest stage, free incisions through the gums
ickened periosteum; when necrosis has taken place, deodorizing
copiously applied: meat beaten to a pulp, and other nourishing
ose portions to be removed as soon as detached.*

CLOSURE OF THE JAWS, with more or less inability to open
uth and to masticate solid food, may be a result of disease of
e implicating the joint; or of rigid cicatrices within the mouth,
ıl after sloughing, whether caused by drinking boiling water,
ıe profuse administration of mercury. The division of any rigid
f cicatrices, the division of the masseter muscles by subcutaneous
, a narrow knife being thrust from the mouth between the
and the skin, an operation which has been successfully per-
by Mr. Fergusson, and the use of a screw dilator, are the only
le remedies.

CTION IV.—AFFECTIONS OF THE MOUTH AND TONGUE.

'UMOURS of almost every kind, including cartilaginous, glandu-
cular, and serocystic, may be found in the cheeks, but the com-
are encysted tumours, containing a glairy liquid. They may
on the inner surface of the lips, or may exist under the tongue,
such tumours are known by the term *ranula*. It was formerly
ed that ranula depended on obstruction of the Whartonian sali-
ıct; but this is not the case. These tumours should be treated
first place by simple free incision, or by cutting out a piece of
. Should this not suffice, the interior may be touched with
caustic, or a small seton be passed through it, to cause it to sup-
and waste away; or the cyst, if loosely attached, may be dis-
ıut.

like, or almost solid, and the cysts themselves thickened and closely adherent to the surrounding parts, so as not to be detached without great bleeding. In any such case, if the tumour is too large to be extirpated, or its contents too solid to be removed by an incision within the mouth, an incision must be made in the middle line beneath the jaw, between the muscles which pass from the jaw to the hyoid bone; or wherever else it is most superficial. The contents must be removed; as much of the cyst as can be detached, be cut off; and the remainder left to suppurate. Mr. Mayo fills the remainder of the cyst with lint dipped in turpentine, both to check bleeding and to cause the cyst to be quickly thrown off.*

II. TONGUE-TIE signifies a prolongation of the frænum linguæ, confining the apex of the organ to the lower jaw. It is usually detected by the difficulty which the infant has in sucking; and may easily be relieved by dividing the frænum with a blunt-pointed pair of scissors, taking care to direct their points downwards, and to keep as close to the lower jaw as possible, so as to avoid the lingual artery.

III. WOUNDS of the tongue are liable to be attended with severe hæmorrhage from the lingual artery or from veins. If the bleeding orifice cannot be tied or controlled by acupressure, one or more ligatures must be introduced with curved needles, so as to include and constrict the bleeding parts, or a heated iron may be applied. Children are apt to inflict very severe bites, even sometimes almost biting off the end of the tongue. The author has treated several such by leaving them entirely to nature. He has known surgeons put themselves to very great trouble to introduce sutures, but the patient fared none the better.

IV. INFLAMMATION of the tongue, known by great swelling, tenderness, and difficulty of speaking, and of deglutition; generally accompanies severe salivation; but it may occur in an acute form independently of this cause. It must be treated by purgatives and gargles; by leeches, incisions, and the antiphlogistic regimen generally, if necessary. If abscess form, the fluctuating part should be opened. Abscesses which form under the tongue may cause suffocation by their pressure on the glottis: an incision beneath the chin, through the mylo-hyoid muscle is the only resource.†

V. HYPERTROPHY.—Enlargement, without tenderness or structural disease, sometimes affects the tongue, causing it to protrude permanently from the mouth. It is usually the result of an attack of acute inflammation, which has caused the tongue to protrude. On this point the

* Mr. Mayo's case, Lancet, 1847, i. 667; also Fergusson's Pract. Surg., 3rd edit., p. 599.

† Sometimes the tongue enlarges suddenly to an immense size, so as almost to cause suffocation, but without any symptoms of inflammation, properly so called. A case which proved fatal, in spite of bleeding, leeching, calomel, and incisions, is related by Mr. Lyford, of Winchester, in the Lancet for 1828, p. 161 a similar case, cured by purgatives and incision, by Mr. Taynton, Med. Gaz., vol. xii., who speaks of it as the only case he had seen in a practice of forty years; and one by Mr. Collins (ib., p. 642), in a pregnant woman, cured by an incision in the raphé on the under surface.

author believes the following case will supply a practical hint. He was some time since consulted in a case in which the tongue had protruded largely from the mouth, in consequence of severe salivation. He found that the continuance of the protrusion was owing, first, to the impaired function of the recently-inflamed organ; and, secondly, to some amount of constriction by the teeth; but gentle pressure easily caused it gradually to return into the mouth. Had it been left to itself it might, to all appearance, have remained protruded for ever. Hence, in all such cases, the surgeon should replace the tongue, as soon as the acutest stage of inflammation has passed, and should not wait for it to go in of itself.

Treatment.—Steady compression should be first tried, by compress and bandage. Should this fail, a A-shaped piece should be removed, by the écraseur.

VI. ULCERATION of the tongue presents many varieties. One of the commonest is that which arises from the irritation of decayed teeth, and is usually soon cured by removing the cause, and using aperients and an astringent gargle. A more troublesome sort begins with aphthous spots on the tongue or any other part of the inside of the mouth, which produce excessively irritable and tedious ulcers in succession. Aperients and tonics, and the application of nitrate of silver, or lin. æruginis are the remedies. Secondary and tertiary syphilis are also liable to cause ulcers here; which are to be recognized by the history of the patient, and by the benefit probably derivable from sarsaparilla with iodide of potassium.

VII. CANCER of the tongue usually soon produces a deep excavated ulcer, which will be distinguished from either of the simpler kinds by its having been preceded by nodular enlargement, and by pain and embarrassment in the use of the organ. In the case of the late Bransby Cooper, neuralgia of the right side of the neck and face was the first symptom; followed by difficulty of swallowing and articulation, fetid breath, and loss of flesh. Death occurred from arterial hæmorrhage in ten months. There was found a deep excavation at the root of the tongue; the tissues around, as well as the muscles about the os hyoides and some adjoining lymphatic glands, infiltrated with cancer.

VIII. EPITHELIOMA of the tongue may be scarcely less fatal than cancer, from which it may be difficult to distinguish it except by microscopical examination. A typical case of it occurred in the person of the late Professor John Reid, of St. Andrew's. His age was 39, and health good. In December 1847, he noticed a small ulcer on the right side of the tongue; it slowly extended and acquired hard everted edges, but caused little inconvenience. In July 1848, it had attained the size of a five-shilling piece; its surface and edge were ragged, and it caused considerable pain, especially at night. A hard ridge could be felt all round the ulcer, and glands enlarged beneath the jaw. The health, by the end of August, had completely given way from the pain, when the diseased part of the tongue was excised by Mr. Fergusson. In less than a month the wound had healed, and the health was re-

established. In November the enlarged glands were removed by Dr. Duncan. The disease returned in the cicatrices of the wounds, and spread chiefly in the upper part of the neck. Death occurred in July 1849. The diseased part of the tongue and the gland, which were mixed, were infiltrated with epithelium. Paget observes, however, that a collection of epithelium may form deep in the tissues of this organ, without any primary changes of its surface.

Treatment.—In any such cases, and in the case of any ulcer, when the failure of all treatment gives room for suspicion, free and *early* extirpation should be performed, by means of the écraseur. Amongst palliative measures the application of ice may be found useful.

The cases of these two eminent members of the profession present a subject for useful comparison. The epithelioma was here quite as malignant as the cancer. Yet diseases, though equally fatal, should not be confounded, if their anatomical elements are distinct.*

SECTION V.—AFFECTIONS OF THE TEETH AND GUMS.

I. LANCING OF THE GUMS of children may be performed for two reasons. If the gum is swelled, inflamed, and tender, whether or not a tooth be quite ready to come through, a free incision may be made with a fine lancet, for the purpose of letting blood flow. But if it is tightly stretched over a tooth, which is bursting through, the incision should be carried down to and all along the tooth, so as to release it entirely. In either case a sharp and pointed instrument should be used, to be thrust in with its back to the teeth, and made to cut its way out. The common gum lancets are blunt and butcherly.

II. IRREGULARITY OF THE PERMANENT TEETH is a consequence of contracted and ill-formed jaw-bones. If either of the canine teeth or of the incisors of either jaw project much, the patient should be taught perpetually to endeavour to push it back into its proper position with his fingers. But if at the age of fourteen or fifteen this method has not succeeded, and the teeth are much crowded, the projecting tooth may be removed, although in many cases it is better to sacrifice one of the bicuspides to make room for it. If a growing child is *underhung*, so that the under incisors come in front of the upper ones when the mouth is shut, or so that the teeth meet at the cutting edges, instead of the lower teeth being received within the upper, the child should be encouraged daily to push the upper teeth forwards with its tongue and fingers: and should frequently put the end of a spoon-handle behind the upper incisors, and then close the mouth, using the spoon as a lever to press the upper teeth forwards and the lower ones backwards. But if these simple means do not succeed, recourse should be had to the appliances used by professional dentists.†

* For Dr. Reid's case, see Hughes Bennett on Cancer, &c.; Arnott, Med. Chir. Trans., vol. xxii. The author has to thank Mr. Birkett and Mr. Avery for some particulars of Mr. Cooper's case.

† A good account of which will be found in Tomes's Lectures on Dental Surgery.

The *wisdom teeth*, especially in the lower jaw, are extremely liable to be misplaced, growing directly outwards or inwards, and producing ulceration of the cheek or tongue; or projecting forwards against the neighbouring molar, or backwards into the coronoid process, or even being contained within a tumour in the substance of that process. Tumours of either jaw may likewise arise from mal-development of either of the other teeth.

III. FRACTURE AND DISLOCATION OF TEETH.—If a portion of a tooth is broken off, without exposing the pulp cavity, the exposed surface should be filed smooth, and then no inconvenience will probably follow. If it is snapped off at the neck, and the pulp cavity is exposed and very painful, it should be touched with lunar caustic, and the mouth be frequently bathed with strong poppy decoction; and when pain and tenderness have ceased, an artificial tooth may be fastened by a pivot to the stump. If, however, the root of the tooth is loosened by *inflammation*, it had better be extracted at once. If a tooth is loosened by a blow, it should be fastened by silk to its neighbours. If a tooth is entirely driven out, it should be replaced as soon as bleeding has ceased, and be fastened in by silk; no food should be allowed that requires mastication, and inflammation should be combated by repeatedly leeching the gum.

IV. CARIES OF TEETH signifies a successive softening and decay, gradually spreading till it reaches the central cavity of the tooth, which from that time is subject to fits of toothache. It depends on original imperfect formation of the enamel and bone, especially in scrofulous and ill-nurtured persons, and may further be promoted by any circumstances which lower the general health. It is very frequently a consequence of pregnancy, and of nursing; it may follow any serious illness, or loss of strength, or the abuse of mercury. It is rank nonsense to allege that it may be caused by steel or acids used as tonics, or by any abrasion or loss of enamel. It is as truly a constitutional disease as phthisis or scrofula. The author has seen the four upper incisors quite rotten in a scrofulous child at thirteen months.

Treatment.—The whole of the decayed portion should be removed, and the cavity be filled up with gold, or an amalgam of silver and mercury, or of silica and gutta percha. If the decay has laid open the pulp cavity, it may be necessary first to use some applications, under which the pulp may heal up and close over by bone, or at least may get into such a state as to yield no discharge; for it is of no use to stop a tooth if there is any secretion of purulent matter from the pulp underneath. The best application seems to be creosote, inserted into the pulp cavity on a little bit of cotton wool, and over that another bit of cotton wool dipped in mastic varnish, F. 183. This will require to be changed once in two or three days, till all discharge ceases. But if the pulp continue irritable, tender, or bleeding, it will be necessary to deaden it with a little fragment of nitrate of silver, or to destroy it by a minute quantity of arsenic. After this, which is not

a painful process, the cavity may be again dosed with creosote, till it ceases to discharge. Then it may be stopped by some gutta percha and silica; and lastly, comes one of the neatest processes of scientific dentistry. A fine hole may be bored through the *gum* into the pulp cavity. Should any discharge form in that cavity, it will drain out of this aperture, and thus a tooth with the pulp destroyed may continue useful for years.

A great deal may be done yet, to abridge the sufferings of children, by looking after *caries of the milk teeth*. These should be stopped by some varnish on wool to protect them from the food.

There is a prejudice against extracting any of the first set of teeth in children, however carious, on the supposition that the jaw might become contracted, and the permanent teeth crowded. Mr. Tomes tells the author that this fear is groundless. These teeth certainly should not be extracted needlessly: but it is better to do so than to allow them to cause much pain, or gum-boils; or to tempt the child to bolt his food from the pain of chewing it.

Every case in which teeth decay with rapidity, should be looked upon as requiring medical treatment; and in particular the administration of cod-liver oil, steel, bone-dust, &c.: F. 201.

V. TOOTHACHE.—(1.) *Inflammation of pulp.* When the tooth-pulp has been laid bare, it is liable to injury from food which may be forced right down into the fang, or from hot, or cold, or acrid liquids; and will inflame likewise from cold, errors in diet, or anything else that disorders the general health. The pain is most agonizing; the tooth becomes exquisitely tender; then it rises in its socket from infiltration of the soft tissues there; the periosteum and gum swell and inflame, and if the case goes on, suppuration occurs in the socket and outside it, and an abscess forms.

Treatment.—If the tooth is useless it had better be extracted at once; if likely to be useful, the cavity should be cleared of foreign substances, and then be treated with creosote as above. If the patient is feverish, and the tongue foul, a dose of calomel and colocynth, broth diet, and warm fomentations will do good; so also will washing out the mouth with a tumbler of hot water containing a teaspoonful of bi-carbonate of soda. There are other measures too, such as a leech; an incision of the gum on either side of the tooth, down to the bone; solution of tannin in ether, or of camphor in chloroform, or of alum in nitric ether; the use of pellitory chewed, &c.

2. *Irritable gum.*—The gum between a decayed tooth and its neighbour, may become spongy and swelled, and excessively sensitive; giving rise to a very wearing kind of toothache; and causing excruciating pain if a portion of the food happens to be pressed down upon it. This may be relieved by a deep incision through the swollen gum, and the use of tannin gargle, of pellitory chewed, and of aperients, F. 34, 35.

3. *Neuralgia*—Whether it occurs in teeth that are entirely sound, or partially carious, is to be distinguished by its occurring in paroxysms which come and go suddenly, in more or less regular intervals.

ery common in the earlier months of pregnancy, and other
ns of disordered health.
tment.—Quinine in large doses, together with aperients and
es, are the most successful remedies.
heumatic toothache,—flying about the jaw, and affecting several
turns, is not relieved by extraction, so much as by blue
aperients, with small doses of colchicum, followed by the
of ammonia, in half-drachm doses, every four hours, or the
f potassium with bark.*
ther of these conditions may lead to a thickening of the fang
deposit. It sometimes occurs on teeth that are perfectly
ut more generally on carious teeth, or stumps. The tooth is
long, and aches obstinately. The excessive pain of this affection
eral only to be relieved by extraction.
NECROSIS OF TEETH.—A tooth is said to be necrosed when
ecome black and unsightly, and loose in its socket. This affec-
y be caused by blows which have torn across the nutrient
or by inflammation of the pulp (perhaps from the abuse of
). Extraction must be performed, if the tooth cause inflam-
r other inconvenience.
EXTRACTION OF TEETH.—Nothing which relieves human
ought to be slighted or despised. No wise surgeon therefore

to make himself acquainted with the way of pulling out teeth

* Vide Dr. Watson's Lectures, Lect. 39.

with dexterity. It is an operation which is easily performed by any one who has the proper instruments, and uses them with ordinary care;

and it is one which if unskilfully or carelessly performed may lead to very serious results, to say nothing of the suffering which it inflicts. We beg the reader, therefore, to study well the construction of the instruments employed, and to practise with them on the dead body, before he tries his hand on the living. They are the forceps, the elevator, and the key.

1. *The forceps* is the instrument that is now generally employed by dentists. It should be made with sharp edges, so that it may be pushed up between the tooth and the gum, and should seize the tooth by its neck, close to the alveolus. For this purpose, also, the jaws of the instrument should be made to incline towards each other in such a way, that they may slip up and embrace the neck of the tooth accurately when the handles are pressed together; and they should be ground in such a manner that they may be adapted accurately to the shape of each tooth. For this purpose the surgeon will require seven sets of instruments. One instrument is required for the left upper molar (fig. 1), and one for the right (fig. 2), because of the peculiar conformation of those teeth. One will serve for the lower molars of either side (fig. 3); one will serve for any single-fanged tooth

of the upper jaw (fig. 4), and one for any single-fanged tooth of the lower jaw (fig. 5). Stumps in the upper jaw may be extracted with

the instrument fig. 6, and those in the lower jaw with fig. 7. The instruments here depicted were devised by Mr. Tomes some years

since, and are made by Evrard, who lives opposite the Middlesex Hospital.

In extracting teeth by the forceps, there are two things to be done; first, to loosen the tooth, and then to pull it straight out. In extracting the incisors and canines of the upper jaw, they may first be loosened by giving them a gentle twist, combined with a slight rocking motion, and then may be pulled perpendicularly downwards with a slight inclination backwards. The incisors and canines of the lower jaw are to be loosened by giving them a firm but gentle motion backwards and forwards, and then may be pulled straight up. The bicuspides and molars are to be loosened by moving them from side to side, so as to make the alveolar process yield a little, and then they may be pulled perpendicularly, upwards or downwards, as the case may be. The operator should grasp the forceps firmly, in such a manner that it may move altogether with his

hand; but yet not so forcibly as to run the risk of crushing the tooth.

2. *The elevator* is highly useful for stumps, and for old straggling teeth. The point is to be thrust firmly down between the tooth and its socket, and then by bringing the instrument into a horizontal position, and making a fulcrum of the edge of the alveolar process, or of the adjoining tooth, or of the operator's fingers, the tooth may be lifted out.

2. *The key* is an instrument that is often employed for the extraction of the bicuspides and molars; but it is more painful than the forceps, and every one must know instances of laceration of the gum, and splintering of the alveoli, followed, perhaps, by tedious exfoliation, that have been produced by the clumsy use of this instrument; not to mention the risk of the claw slipping from the decayed tooth and dragging out a sound one instead. If, however, it is preferred, care should be taken to select an instrument of proper size, and to place the fulcrum in a proper position. If the key is too small, and the fulcrum too high, very probably the crown of the tooth will be snapped off. If the key is too large, and the fulcrum too low, either the claw of the instrument may be snapped across, or the alveolar process be extensively splintered. The adjoining figure is intended to show the right position, which will draw the tooth more or less perpendicularly from its socket. The fulcrum ought to be placed on the *inner* side, for the bicuspides of the lower jaw, and molars of the upper; and on the outer side for the molars of the lower jaw. The *dentes sapientiæ* of the upper jaw should never, according to Bell, be extracted with the key, because of the delicate texture of the bone on which the fulcrum must rest.

Before extracting teeth with the key, it is usual to cut away the gum from their necks by means of a gum lancet; a practice only necessary if the gum has been subject to repeated inflammation, which renders it adherent to the tooth, and liable to be lacerated on its removal; or secondly, in order to afford room for the claw, if the tooth has decayed down to the gum. Some persons, instead of using a lancet, separate the gum by means of a small tenaculum.

VIII. HÆMORRHAGE *after Extraction of Teeth.*—This operation may be followed by very severe and dangerous hæmorrhage, which sometimes appears to come from the dental artery at the bottom of the socket; sometimes from the gums, when they have been long diseased. The cavity must be cleared of all coagulum; and be cleansed with a bit of lint dipped in solution of alum. Should this not answer,

the alveolus must be plugged in the following way: One end of a long thin strip of lint is to be firmly pressed into it, so as to come into contact with its very bottom, and the remainder in successive portions is to be forced in till the socket is filled up to the level of the gum. A compress should then be placed on the part, thick enough to be pressed upon by the antagonist teeth, and the mouth should be kept firmly closed by a bandage passing from under the chin to the vertex.

IX. TARTAR, or *salivary calculus*, is an earthy matter deposited on the teeth from the saliva. It is found most abundantly on the superior molars and inferior incisors, obviously because those teeth are nearest the orifices of the salivary ducts. If suffered to accumulate, it causes inflammation and absorption of the gums, and gradual loosening of the teeth.

Treatment.—The deposit of this substance is to be prevented by cleaning the teeth twice a day with a soft tooth-powder (precipitated chalk is the best) and a little soap, and by the use of a quill toothpick. The hairs of the tooth-brush should be soft, and not too closely set; so that they may penetrate the better into the interstices of the teeth. When any quantity of the tartar has accumulated, it should be removed by the *scaling instruments*. The edge or point of the instrument is to be introduced between the concretion and the gum, so as to detach the former in flakes; in the meanwhile a finger or thumb, guarded with a towel, should be pressed firmly on the cutting edges of the teeth, so that they may not be loosened by the force necessarily employed. Sometimes a small portion of this substance is found sticking in the orifice of one of the salivary ducts, and creating great discomfort by its irritation. It may easily be removed.

X. INFLAMMATORY SOFTENING AND ABSORPTION, vulgarly called *scurvy* of the gums, generally affects middle-aged or elderly people, and may be a consequence of the accumulation of tartar, but more frequently depends on a congested state of the liver and bowels. The gums are swollen, spongy, exceedingly tender, and subject to constant aching pain, and they bleed on the slightest touch. If the disease proceeds, they separate from the teeth; the alveoli gradually become absorbed, and the teeth loosen, and at last fall out. These consequences are sometimes speedy, and are attended with suppuration in the alveoli; but more frequently they are slow, the teeth dropping out one by one in the course of years.

Treatment.—The gums should be unloaded by deep and free scarifications and repeated leechings; the bowels should be well cleared by a course of purgatives; and gargles should be employed to correct the secretions of the mouth, and excite the vessels to contract. Whilst there is much pain and softness, the soothing gargle, F. 113. Subsequently, recourse may be had to F. 109, 111, &c.

XI. GUM-BOIL (*alveolar abscess, parulis*) is a small abscess commencing in the socket of a tooth, and bursting through the gum, or sometimes through the cheek. It is usually caused by the irritation of a dead or carious tooth. In neglected cases, extensive exfoliation of the bone may follow.

Treatment.—Fomentations; removal of the tooth, if much decayed; and an incision as soon as matter can be detected. If the tooth is extracted soon, the sac of the abscess very often comes away with it.

XII. EPULIS signifies a fibro-plastic or fibrous tumour of the gum. It generally commences between two teeth, which it gradually separates, then loosens, and finally displaces, and may spread so as to involve several of them. Or it may begin on the free surface of the gum, internal or external, and may form a tumour flat, prominent, polypous, or pendulous. This tumour is indolent, painless, and of slow growth; but it ought always to be extirpated without delay, because it is liable to increase, and might become the seat of offensive ulceration, to say nothing of the deformity and inconvenience which it occasions.

If possible, it must be cleanly shaved from the periosteum; but if necessary, the tooth on either side must be extracted, and the tumour entirely cut out. A portion of the alveolar process must be removed likewise, if necessary, in order to render the extirpation complete.

A similar tumour is sometimes formed when a dead portion of the root of a tooth remains in its socket, and the gum has healed over it. The tumour should be entirely removed with the knife, and the extraneous body should be sought for, and be extracted, if possible.

Cancerous tumours of the gums are exceeding rare; they will, however, be recognised by their rapid growth, and tendency to hæmorrhage.

* This cut represents an epulis, in a patient of Mr. H. Walton's; it had existed many years, and interfered with the movements of the tongue and use of the jaws, and so produced great emaciation.

CHAPTER XV.

SURGICAL DISEASES AND INJURIES OF THE NECK.

SECTION I.—SURGICAL DISEASES OF THE FAUCES, TONSILS, AND UVULA.

1. ACUTE TONSILLITIS, QUINSY, or INFLAMMATION OF THE TONSIL, is known by rapid swelling of the part, considerable throbbing pain; deglutition difficult, perhaps impossible; headache, foul tongue, and fever. It must be treated by poultices, a dose of calomel followed by purgatives, inhalation of the steam of hot water, and gargles calculated to promote the secretion of saliva (F. 107). If the gland continue to swell, or if it occasion any embarrassment to the breathing, an incision should be made into it to unload the vessels, and give exit to matter. The tongue should be kept down with one forefinger, whilst a straight bistoury, wrapped round with lint except an inch and a half of its point, is plunged directly into the tumour, and made to cut its way out towards the median line. Abscesses behind the pharynx require similar treatment.

II. CHRONIC ENLARGEMENT OF THE TONSIL is a frequent sequel of inflammation, especially of reiterated catarrh in scrofulous children. It causes sundry inconveniences. The parts are liable to frequent attacks of acute inflammation; deglutition is impeded; the voice is rendered hoarse; respiration is noisy and laborious, especially during sleep; the diseased state of mucous membrane is extremely liable to be continued into the ear, as we explained when treating of throat deafness, and to lead to disorganization of the delicate structures in the tympanal cavity; and suffocation has even been caused by viscid mucus entangled between the swollen glands.

Treatment.—In the first place the system must be strengthened, and the secretions be kept up by proper tonics and alteratives. Steel, especially the iodide, bark, cod-liver oil, or F. 87, 65, 41, 37, &c., may be administered with benefit. At the same time contraction must be promoted by astringent gargles, F. 109, by swabbing the throat once a day with a lotion of arg. nit. ℈j, aq. dest. ℥j., or liq. iodinii, and by applying stimulating or iodoretted liniments to the skin.

The method of *swabbing* is simple. A piece of sponge the size of a walnut must be put over the end of a stick, cane, or whalebone, in such a way that it completely covers the end of the stick; and it must be firmly sewn or fastened on. The patient sitting, opens his mouth, and the surgeon having made the sponge to imbibe a solution of nitrate of silver, presses down the tongue with the left forefinger, introduces the sponge into the pharynx, and fairly swabs out every part of it.

Inhalation of vapour is another remedy of the greatest possible efficacy when the mucous membrane of the fauces, mouth, and tonsils

is flabby and swollen; as well as in the catarrhal rhinorrhœa, in throat deafness, and in coughs attended with copious expectoration. In order to inhale effectually it is necessary to have some apparatus; and the essence of all such apparatus is, that they have one passage for introducing the external air below the surface of the liquid whose vapour is employed; another through which the patient can draw the air mixed with vapour into his mouth. The cheapest and most efficient inhaler the author is acquainted with is a simple double tube with mouthpiece, sold by G. Mawe, of Aldersgate Street. But, for the sake of the poor, he recommends one to be made thus:—Take any large stone or glass bottle with a wide mouth, and a soft cork; take two pieces of German glass tubing; bend the shorter one at an angle to serve as mouthpiece; put the ends into a gas flame, to melt off any sharp edges; bore the cork, by means of a rat's-tail file, with two holes for the tubes to pass through; put the necessary liquid into the bottle; insert the cork with the tubes, and the machine is ready for use. The most efficient vapours are evolved from boiling water, to which twenty drops of creosote, or the same of tincture of iodine, have been added.

If these measures fail, and such an operation is deemed necessary, part of the gland should be removed with the knife—a much more expeditious and cleanly method than the ligature. The surgeon seizes the tumour with a hook or forceps (depressing the tongue with its handle), then introduces a blunt-pointed curved bistoury, and shaves a thin slice off, cutting upwards, parallel to the isthmus faucium. The nearest half of the blade of the bistoury should be wrapped in lint, to prevent the lips from being cut; and in operating on the right side, the surgeon will find it most convenient to cross his hands, the left, holding the forceps, being undermost. Very little should be removed; not only to avoid hæmorrhage, but likewise because of the possible truth of Mr. Harvey's theory that removal of the tonsils interferes with the development of the genital organs. There are certain *guillotine* instruments which can also be very adroitly used for this purpose. Specimens of excised tonsils which the author has examined have been infiltrated with cells, most of them exactly resembling pus.

III. ENLARGEMENT OF THE UVULA produces tickling cough and expectoration by irritating the larynx. If it does not yield to the treatment directed for enlarged tonsil, it should be stretched and steadied with a forceps, and be cut through the middle with a pair of long scissors.

Our design being to describe such affections only of these parts as

require surgical remedies, we must pass over the various other sorts of sore throat which are assigned to the physician; merely remarking that the affection which we have described as *quinsy*, is phlegmonous and deep, yet that the superficial and catarrhal inflammations require nearly similar treatment.

SECTION II.—SURGICAL AFFECTIONS OF THE PHARYNX AND ŒSOPHAGUS.

I. SPASM OF THE ŒSOPHAGUS (*spasmodic stricture*) is known by its generally occurring in sudden fits—the patient at a meal finding himself altogether incapable of swallowing, and the attempt to do so producing spasmodic pain and a sense of choking. The *diagnosis* between this and the *organic* or *permanent stricture* is founded on the suddenness of its accession: it being much better at some times than at others; and the fact that the bougie, if passed, either meets with no obstruction, or with one that very easily yields.

Treatment.—This affection always depends on a weakened or hysterical state of the system, or on the presence of some other disorder, as has been mentioned whilst treating of neuralgia. Brodie relates a case that ceased on the removal of bleeding piles; and Mayo another that was cured by relieving chronic disease of the liver. Tonics, antispasmodics, and alteratives, especially iron with aloes and galbanum at bedtime; exercise in the open air; the shower-bath, and other forms of warm and cold bathing; great attention to the diet; care not to swallow anything imperfectly masticated or too hot; and the occasional passage of a bougie, are the remedies.

II. PALSY OF THE ŒSOPHAGUS occasions inability of swallowing, but without pain or other symptoms of spasm; and a bougie, when passed, meets with no obstruction. It generally depends on organic disease of the brain or spinal cord, which must be examined into and cured if possible. The patient should be fed by the stomach-pump, by nutrient enemata, and by pushing soft food occasionally down the œsophagus with a probang. The palsy has sometimes been temporarily relieved by electrifying the patient on an insulating stool. Nutrient enemata should be composed of very strong beef or mutton broth, without salt or spice. The quantity injected at one time should not exceed four ounces; and if the rectum does not retain it a few drops of laudanum should be added.

III. DILATATION AND SACCULATION.—The œsophagus has been found after death exceedingly dilated. The symptoms during life were great *dysphagia*,—food, when swallowed, never seemed to reach the stomach, and was vomited in a few minutes. If this condition should be ascertained during life, the patient should be fed as in palsy. Sometimes a blind pouch is connected with the œsophagus, and occasions great distress in swallowing, by intercepting the food. It may be formed either by a protrusion of the mucous membrane through the muscular fibres, or by the sac of an abscess which has burst into the

tube. The only remedy is to feed the patient constantly with the stomach-pump, so that the pouch may be allowed to close.

IV. PERMANENT STRICTURE of the œsophagus signifies a narrowing produced by a thickening of its coats, which form a firm ring, encroaching on the canal. It is generally found just below the termination of the pharynx; that is, opposite the cricoid cartilage, and is most frequent in females. The *symptoms* are, difficulty of swallowing, noticed probably for years, gradually increasing; never absent; and occasionally aggravated by fits of spasm. The act of swallowing frequently produces pain in the chest, which shoots between the shoulders, and up to the head. When a bougie is passed, it meets with an obstruction. The *causes* of this affection are generally unknown: sometimes, however, it appears to be a sequel of repeated quinsy, or to be caused by swallowing boiling or corrosive liquids: in one case it appeared to be induced by violent retching in sea-sickness. The *prognosis* is always serious, especially if the complaint is of long duration. If unrelieved, its *consequences* will be ulceration of the œsophagus, either above or below the stricture, with salivation, vomiting of purulent matter, and impossibility of deglutition, which in no long time will be followed by death. The fatal termination may be owing either to sheer starvation, or to the irritation of the local disease, or the extension of ulceration to the lungs.

Treatment.—A mild course of mercury, so as just to affect the gums;—occasional leeching, to relieve exacerbations of pain or spasm;—hyoscyamus or conium, if there be much irritability;—a seton between the scapulæ; and the occasional passage of a bougie, or of a *ball probang*—an ivory ball attached to a piece of whalebone or flexible wire—or of a piece of sponge moistened with a weak solution of nitrate of silver, and attached to a stout copper wire, as recommended by Sir C. Bell, are the remedies. The method of introducing the bougie is as

* This cut exhibits a stricture of the œsophagus. From the Museum of the Middlesex Hospital.

follows:—The patient sits upright, with the head thrown as far back as possible, and the mouth wide open. The bougie, which should be previously warmed in the hand and oiled, and gently curved, is passed down into the pharynx in such a manner that its point may slide along the vertebræ. In order that it may not excite cough by interfering with the epiglottis, the patient should be directed to protrude the tongue from the mouth as far as possible; or to perform the act of deglutition just when the bougie is entering the pharynx. If it meets with an obstruction in its descent, the surgeon should slightly withdraw it, then again press it gently against the obstruction, increasing the pressure for a few minutes if it gives no pain. If it fail to pass, a smaller one should be tried.

V. ULCERATION.—"Simple but fatal ulceration," as Mayo correctly called it; that is to say, *phagedænic* or *corroding* ulceration, without the pre-existence of epithelioma or of cancer (compare pp. 80, 113), is liable to affect the pharynx at the level of the cricoid cartilage, or the œsophagus lower down. If the finger or a bougie is passed, its point returns marked with bloody pus. The consequences are always the same;—exhaustion from the irritation of the disease, and from the inability to swallow; or possibly a more speedy death from perforation of the aorta or of the pleura.

VI. EPITHELIOMA and CANCER also sometimes affect this part. The symptoms are alike: burning pain between the scapulæ; and difficulty of swallowing.

Treatment.—A deposit of hard cancer into the walls of the œsophagus will at first be scarcely distinguishable from stricture, and must be treated like it; but when burning pain indicates ulceration, then nutrient enemata, belladonna plasters to the back, opium, ice-cream, &c., should be used to relieve the pain; and a very careful diet, including eggs, meat beat to a pulp, and other nutriment of small bulk.

VII. TUMOURS pressing on the œsophagus, whether abscesses, polypi, aneurisms, bronchocele, or enlargement of the bronchial lymphatic glands, will produce all the symptoms of organic stricture. Aneurisms and abscesses have been burst by the passage of bougies—with, of course, instant death in the former case, and relief in the latter. Before performing this operation, therefore, the chest ought to be well scrutinized by auscultation, to detect any unnatural pulsation or *bruit*; and any signs of embarrassed circulation or respiration should not be overlooked.

Polypus.—Cases are recorded of polypous tumours projecting into the pharynx or œsophagus.*

VIII. FOREIGN BODIES, when fixed in the PHARYNX, or about the

* Vide Sir E. Home on Strictures, vols. i. and ii.; Monro on the Morbid Anatomy of the Gullet, &c.; Brodie on Local Nervous Affections (*spasmodic stricture*); Mayo's Pathology; Stokes in Cyclop. Pract. Med., vol. ii.; and Sir C. Bell's Institutes of Surgery, vol. i.; Arrowsmith's case of Polypus in Œsophagus, Med. Gaz., N. S., p. 165. There is a case of congenital imperforate œsophagus in the Musée Dupuytren, at Paris; it was continuous with the trachea.

aperture of the larynx, or in the œsophagus, produce a sense of choking, and fits of suffocative cough. This accident, if unrelieved, may prove fatal in two manners. The patient may either be suffocated at once, by spasm of the glottis, or, if the foreign substance remains impacted, it may produce ulceration of the parts, attended with exhausting cough and dyspnœa, and profuse fetid expectoration.

Treatment.—The patient should be seated in a chair, with the head thrown back, and the mouth wide open. The surgeon should then introduce his finger, and should pass it swiftly into the pharynx, and search the whole of it thoroughly. When the substance is felt, it may perhaps be entangled in the point of the nail, or curved forceps may be guided to it by the finger. Pins and fish-bones are often entangled about the velum, or in the folds of mucous membrane between the epiglottis and tongue. If the patient has false teeth, the surgeon should take them out, and thus will pass his finger in another inch; and he should remember the proneness people have to swallow false teeth.

If the body has passed into the œsophagus, and it is small and sharp (a fish bone, for instance), it may be got rid of by making the patient swallow a good mouthful of bread. If large and soft (as a lump of meat), it may be pushed down into the stomach with the probang. But large hard bodies, especially if rough and angular (such as pieces of bone or glass, &c.), should be brought up if possible. A pair of long curved forceps, or a piece of whalebone armed with a flat blunt hook, or with a skein of thread, so as to form an infinite number of nooses, are convenient instruments. If the stomach is full, a dose of tartar emetic dissolved in a very small quantity of water may be administered, in the hope that when the contents of the stomach are vomited, they may bring up the offending substance with them. One case is on record in which a chicken-bone lodging in the œsophagus was dissolved by making the patient swallow large quantities of dilute acid. If a foreign body has got into the stomach, the patient should eat plentifully of rice, potato, and suet pudding, so that it may pass through shielded by plenty of fæces. If all means fail, however, and the substance can neither be brought up nor down, and if it be lodged in the cervical portion of the tube, it must be extracted by the operation of œsophagotomy in the following manner.

IX. ŒSOPHAGOTOMY.—The operation should be performed on the side towards which the foreign body projects. Its situation having been ascertained, an incision of sufficient length must be made through the skin and platysma between the sternomastoid muscle and trachea. The cervical fascia must next be divided on a director. The surgeon must then divide the cellular membrane with a blunt knife, or lacerate it with his fingers, avoiding the carotid and thyroid arteries and the recurrent nerve. A common silver catheter may then be passed down the throat, and be made to project in the wound, so that the œsophagus may be opened by cutting on it. This small wound in the œsophagus should be dilated with forceps, in order to avoid hæmorrhage, and the foreign body should then be extracted. This operation has occasionally

been performed for the purpose of conveying food into the stomach in cases of stricture of the œsophagus, but with no very satisfactory results.*

X. USE OF THE STOMACH-PUMP.—The tube of this instrument is to be introduced in the same manner as the œsophagus bougie. It is usual to place a gag in the patient's mouth, having a hole for the tube to pass through, in order that it may not be compressed by the teeth. Before pumping out the contents of the stomach, one or two pints of water should be injected into it, and care should be taken *not to withdraw quite as much* as was injected. More water should then be thrown in, and the process should be repeated till it returns colourless.

The stomach-pump ought only to be employed in those cases of poisoning by opium, of alcohol, or other narcotics, in which the nervous system is rendered so insensible that vomiting cannot be excited. For, in the first place, the operation is not free from danger. It is a well-established fact, that a tube may sometimes be passed into the trachea of a sensible person without creating any peculiar sensation, or exciting cough; but if the patient be insensible, that accident will be much more liable to happen. In fact, a case is on record in which a meddling surgeon, with more zeal than knowledge, did actually pass the tube down the trachea and inject the lungs with chalk mixture, which he had far better have permitted his luckless patient to have swallowed quietly; and Sir C. Bell tells us, that he has seen, on dissection, both lungs filled with broth, which was intended to have been injected into the stomach. Again, it is known that in one case the mucous membrane of the stomach was sucked into the holes of the tubes, and torn into strips—a thing likely to happen if the stomach is pumped too empty. Besides, this artificial evacuation of the stomach is by no means so efficacious as free vomiting, assisted by plenty of diluents. Lumps of arsenic were left in the stomach in the very case just cited, in which the mucous membrane was torn.†

SECTION III.—THE LARYNGOSCOPE.

I. THE LARYNGOSCOPE is a small mirror by which we can see the inside of the larynx. It was invented by Dr. B. G. Babington in 1829, but, like many other inventions, lay dormant for thirty years; for although it was noticed and used occasionally by Trousseau, Liston, and the late talented Mr. Avery; and although it was used to demonstrate the mechanism of the voice by Garcia in 1855, who was the first to obtain a view of his own larnyx, still it was only brought into vogue by Türck of Vienna in 1857, and Czermak of Prague in 1858. To the exertions of these gentlemen is due the present general

* See Arnott on Œsophagotomy, Med. Chir. Trans., vol. xx.; Report of a case in which it was performed unsuccessfully for the relief of stricture by Mr. Watson, of New York, and of two cases in which it was performed for the removal of a foreign body, in vols. ii. and iii. of Ranking's Abstract.

† See an amusing Clinical Lecture on the abuse of the Stomach-pump, by Professor Watson, in Lond. Med. Gaz., vol. xvii.; and Roupell's Illustrations of the Effects of Poisons.

use and application of the instrument. In these islands it has been particularly studied by Dr. George D. Gibb, from whom the writer received much valuable information for previous editions of this book; also by Dr. Morell Mackenzie, Dr. George Johnson, Dr. Walker, junior, of Peterborough, and Mr. Smyly of Dublin.*

II. THE APPARATUS required is first of all a means of illuminating the throat; and secondly, a mirror reflecting to the observer's eye the image of the parts that he wishes to see.

The *illumination* may be direct or reflected. In the direct method, the surgeon places the patient so that a stream of sunshine, or the light of a lamp is turned directly into the throat. Lamps of various kinds are used, and some of them intensified by a reflector behind, or a bull's-eye condenser in front of the flame, or both. But most operators prefer to put the lamp in the same position as it is in for the ophthalmoscope, and to throw the light into the mouth by means of a reflector. This reflector, a circular mirror, may be used as that of the ophthalmoscope, being fixed before the eye, and having a central aperture through which the observer looks. It may be fixed on a large and strong spectacle-frame, or may be attached to a stem which is held between the teeth. Or the reflector may be worn on the forehead, being attached by a ball-and-socket joint to an elastic band which goes round the head.

The *mirrors* are best made of glass silvered, attached obliquely to stems of adequate length. They are of various sizes, from half an inch in diameter upwards, and are usually square, with the angles rounded off.

III. IN USING THE LARYNGOSCOPE the practitioner should begin upon himself. There are many methods, but the least complex is that of Dr. G. Johnson, who sits before a common looking-glass, and throws the light of a moderator lamp into his throat. The practitioner must first learn how to warm the mirror very gently at the lamp, so as neither to crack it nor spoil the silvering by the heat, nor yet to have it so cool as to condense the breath. The next thing is to manage the tongue. Most people by a little practice can learn to press the tip behind the lower teeth, and to keep down the mass of it out of sight; if the patient cannot do this he must put it out as far as possible, take hold of it with a handkerchief in his left hand, and keep it well down, and the hand out of the way of the light. Then the practitioner introduces the warmed mirror, holding it against the soft palate and uvula, which he gently lifts without touching the pharynx. Whilst he perseveringly works at this part of his experiments, he will learn, if he did not know before, what the nausea, giddiness, heat in the forehead, and universal discomfort are that belong to sea-sickness. He will probably be shocked at the whiteness of the back part of his tongue; then

* See Dr. Gibb's Translation of Czermak on Laryngoscope, New Sydenham Soc., 1861; on Diseases of Throat and Windpipe, 2nd edit., 1864; Dr. G. Johnson's Lectures, Lancet, 1864, vols. i. and ii.; Dr. Walker's Papers in British Medical Journal, 1862 and 1863; Dr. Morell Mackenzie, Practical Hints, Med. Times, April 19, 1862; On Hoarseness, Galvanism, &c., 1863; Smyly's Lectures on Laryngoscope in Dublin Medical Press, 1864.

will get a view of his epiglottis, and at last will be rewarded with a view of the aperture of the glottis, and would do well to study the natural appearance of the parts, and their movements in swallowing, and in uttering the broad A.

IV. Rhinoscopy.—By elevating the soft palate with a hook which is part of the laryngoscopic apparatus, and introducing a mirror with its face upwards, the practitioner may get a view of the posterior apertures of the nares, tubinated bones, and adjacent parts. This inspection is particularly useful in the diagnosis of polypi and other tumours, p. 477.

V. The Use of the Laryngoscope is twofold: in diagnosis, and in the application of remedies. In diagnosis it reveals the presence of foreign bodies: it shows whether the muscles of the larnyx are paralyzed or no; and whether either or both vocal cords are moveable; whether the surface is smooth or ulcerated; whether swelled or not from inflammation and œdema; and whether tumours exist or not. As for the application of remedies, that one which seems almost universally applicable, to this and to all other cases where it is required to deaden an over-sensitive surface to astringe and diminish over-secretion or œdema, and to modify the surface of ulcers, is the strong solution of nitrate of silver twenty grains to the ounce. This is conveniently applied by means of a brush bent at an angle, and made by Weiss. Foreign bodies can be seen, seized, and extracted, œdema scarified, tumours removed with the laryngeal écraseur, and galvanism applied by means of a conductor invented by Dr. Morell Mackenzie.

SECTION IV.—SURGICAL AFFECTIONS OF THE LARYNX AND TRACHEA, INCLUDING TRACHEOTOMY, AND THE VARIOUS CIRCUMSTANCES WHICH REQUIRE IT.

I. Foreign Bodies in the Larynx and Trachea.—(*a*) It sometimes happens that a person who is busily laughing and talking during a meal, suddenly rises from table, attempts to put his finger into his throat, speedily turns blue in the face, and then drops down dead. This arises from a piece of food getting into the *rima glottidis;* a thing liable to happen if a sudden inspiration be made through the mouth, as in laughing, when the mouth is filled with food. It rarely happens that the surgeon arrives in time to do any good; but if he should be promptly on the spot, he ought to search the pharnyx with his fingers, to ascertain whether the obstructing substance can be removed; and if not, he ought to open the air-passage immediately; and to pass a probe up into the larnyx through the wound, so as to push the foreign substance back into the mouth.

(*b.*) It may be impacted in the ventricles of the larnyx or upper part of the trachea; in which case it will probably produce violent spasmodic cough and difficulty of breathing, together with a fixed pain referred to one particular spot—a croupy sound during respiration, which may be heard by the stethoscope most distinctly at the seat of that pain; loss of voice, and probably an acute attack of in-

flammation. Here the laryngoscope will be of service. Dr. Gibb has twice by means of forceps removed a pin sticking across the larnyx. In another case a piece of walnut shell was seen but could not be removed, and was afterwards coughed up spontaneously. Small irregular bodies, such as bits of apple core, may remain for months. The trachea must be opened if there be risk of suffocation; and after a time if need be, the wound may be enlarged upwards to feel for and remove the intruding body.

(*c.*) The foreign substance may be loose in the trachea; especially if a button, stone, or other smooth body. In this case, the violent coughing and sense of suffocation produced by its first introduction generally subside for a time; but every now and then there are violent fits of coughing and of spasmodic difficulty of breathing, during which the substance may be heard by means of the stethoscope, or perhaps may be felt by the finger to be forcibly impelled against the upper part of the larnyx.

(*d.*) The foreign substance may have passed into one of the bronchi, where, perhaps, it may be detected by causing a whistling or murmuring sound; and it will very probably be dislodged and driven upwards when the patient coughs. The right bronchus is that into which it generally falls, because it is a little anterior to the left, and encroaches a little on the middle line.

It is sometimes difficult to distinguish the symptoms produced by a foreign body in the larynx or trachea from those of croup or laryngitis. But the surgeon may generally pretty confidently decide that a foreign body is present, if the symptoms came on suddenly during a meal;—or perhaps the history will be that the patient was playing with a button, or cherrystone, or some similar body in his mouth, and that he chanced to fall down, when the button disappeared, and the symptoms came on directly afterwards. Moreover, in these cases, expiration is generally more difficult than inspiration, whereas it is usually the reverse in croup. Besides, when there suddenly occurs a fixed pain, and a fixed whistling sound in the larnyx or bronchi, without any other symptoms of croup, the case must almost of necessity arise from a foreign body.* If there is any doubt, the pharynx and œsophagus should be well searched, by finger and probang, to make sure that the foreign body is not *there*.

If any foreign body remain in either bronchus, it sets up more or less irritation: cough, pain, muco-purulent expectoration; perhaps night-sweats, and other signs of hectic.

Treatment.—When any foreign substance has entered the trachea, the indication plainly is, to get it out again; and the great point in the treatment is, to lull the vigilance of the muscles which guard the aperture of the glottis, so as to induce them to let it pass out by the way it entered. For it must be remarked that it is muscular spasm,

* See an interesting paper by Mr. C. Hawkins, and another by Mr. Travers, jun., Med. Chir. Trans., vol. xxiii.; Sir B. Brodie on Mr. Brunel's Case, Med. Gaz., July 7th, 1843; a Review of Gross on Foreign Bodies in the Air Passages, by Mr. Henry Lee, Brit. and For. Med. Chir. Rev., Jan. 1856.

excited by the contact of the foreign body, which not only hinders it from escaping when driven up to the glottis by the breath in expiration, but puts the patient in danger of suffocation as well.

In the first place, therefore, if the substance be moveable, and round, and the symptoms not urgent, let the patient be kept quietly in bed and under the influence of narcotics, in doses proportioned to the age; such as syrup of poppies with tincture of henbane and a little ipecacuanha. Then probably the substance may become coated with mucus, and may be expectorated during an effort at coughing or vomiting.

If the symptoms be more urgent, let the patient be put quickly under the influence of chloroform, with the same purpose of lulling the muscles of the larynx; when narcotized let him be turned upside down; a child may be held with his head downwards, and be slapped on the back without ceremony; for a heavy person an apparatus will be necessary, in order to fasten him into a chair, such as was contrived by Mr. Brunel when he had swallowed the half-sovereign.

But if this proceeding does not answer, or if it seems to induce the risk of suffocating the patient, the air-tube must be opened; and this for two reasons: in order, first, to provide means for breathing; and secondly, to provide, if necessary, for the extraction of the intruding substance. For it must be remarked, that the irritability of the glottis subsides, so that the foreign body may pass through it, so soon as an artificial opening is provided.

II. Laryngotomy and Tracheotomy.—The air-tube may be opened either through the larynx, or through the rings of the trachea. The former operation is the more quickly and easily performed on an adult; it is further from the lungs, and less dangerous. Tracheotomy is more difficult and tedious; but is necessary if there is any idea of introducing a forceps.

Laryngotomy is performed by cutting longitudinally through the skin, then through the *cricothyroid* membrane, which may be felt as a soft depression, an inch below the *pomum Adami*.

Tracheotomy is thus commonly directed to be performed:—The head being thrown back, an incision, an inch and a half to two inches long, must be made exactly in the middle line from below the cricoid cartilage to the top of the sternum. The skin, superficial fascia, and fat, are then divided; the sternohyoid muscles are separated with the point of the knife; the loose cellular tissue and veins are cleared from the front of the trachea with the fingers or handle of the scalpel; the thyroid gland, if in the way, is pushed up; a tenaculum is hooked into the trachea to draw it up slightly and steady it; then the surgeon seizes the moment, and whilst the trachea is stretched, sticks in his knife, with a slight jerk, at the bottom of the wound, and carries it upwards, so as to divide two or three of its rings.

Various other methods of performing Tracheotomy.—There are several instruments and plans which have been devised, for the purpose of rendering tracheotomy a more easy and safe operation. Amongst these we may mention first, Dr. Charles Edwards's plan of operating

above the isthmus of the thyroid gland, and immediately below the cricoid cartilage. The operator should feel for the cricoid cartilage, and ink a perpendicular line, a quarter of an inch long, in the middle line below it. The skin should be drawn up over the thyroid, and then be cut through in this line. Then the cricoid cartilage and first ring of the trachea being made out, the hook of the steel director is to be hooked in just below the cricoid, and made to hold the larynx well

upwards and forwards. It will be seen that the groove of the director is open to the very end, and that on the opposite side to the groove the instrument finishes in a tenaculum hook. This hook then being fixed under the cricoid, and held up with the operator's left hand, a narrow stout scalpel is passed along the groove, with its edge downwards. "Should the thyroid isthmus," says Dr. Edwards, "or any pulsating vessel be in the way below, the puncture should barely admit the extremity of a probe-pointed bistoury;" in which case the bistoury being steadied against the end of the groove may be made to divide two or three rings of the trachea from within outwards in subcutaneous fashion; the soft parts over the trachea can be dilated enough afterwards to admit of the introduction of the tube. Of course if the surgeon chooses to perform the operation below the thyroid gland, this instrument will be equally useful.*

The instrument shown below was devised by Mr. H. Thompson† at the request of Dr. Marshall Hall, who wished to find some

method of opening the trachea most expeditiously and safely. It consists of two blades, united at one end by a hinge; at the other bent downwards at an angle, and furnished with cutting edges, nicely

* Charles Edwards, M.D., Lancet, 1853, vol. i., p. 492.
† Lancet, 1853, vol. i., p. 221.

adapted together, so as when pressed together, to make as it were but one edge. There is a screw, by which the blades may be separated. The patient lies down; the surgeon feels with his left forefinger for the lower edge of the cricoid: holding the instrument in his right, with the blades closed, he introduces the cutting point transversely, in the middle line, about a quarter of an inch below the cricoid, so as to slip the point into the trachea, between the first and second rings. Then the blades are separated by the screw, sufficiently to admit a tube; the screw is then reversed and the instrument withdrawn.

Trocars have been invented for tracheotomy, for which they are dangerous. They should never be used upon children, although they might be introduced between the cricoid and thyroid cartilages in the adult.

The great danger and difficulty of the operation, is the bleeding from the numerous veins which lie in front of the air-tube, and which are kept filled by the embarrassment of the breathing. The instant the trachea is opened, blood rushes in with the air during inspiration, and the patient is very liable to be suffocated. In any such case, the surgeon should not hesitate to suck out the blood and mucus with his naked mouth, or through any catheter or tube, or with a syringe. But in order to prevent this accident, he should use the knife most sparingly, and should be particularly careful not to cut downwards near the sternum. He should separate the tissues and clear the front of the trachea with a blunt hook, or the handle of the scalpel. Bleeding, if arterial, should be checked by ligature; if venous, by iced water, compression with the fingers, the ligature, or actual cautery; and the trachea should not be opened till it is suppressed.

So soon as an opening is made, the foreign body is sometimes expelled with a strong gust of air through the wound; sometimes through the now tranquil glottis; but if not, it may be gently searched for with a probe, and be removed by forceps or by a blunt hook; or the patient being chloroformed, may be turned upside down, and slapped on the back, as we have before said.

If this proceeding be not successful, the patient must be sent back to bed, and be kept slightly narcotized; and after a day or two the effort to remove the foreign body may be repeated. But in this case, and in any other in which the operation was performed for the relief of dyspnœa, a curved tube should be introduced for the patient to breathe through. It should fit tightly into the aperture, and prevent the entrance of blood into the trachea. It should be of such a size, as Trousseau has remarked, that the air may pass through it in respiration without any whistling noise.* When the patient wishes to cough, or speak, or swallow, he must be taught to close its orifice with his finger. It should be double, as represented in the following figure, so that by withdrawing the innermost tube, it may be cleared of any mucus that may accumulate in it. It should have a hole in its convex surface, so

* Trousseau, L'Expérience, Nov. 5, 1840; Clin. Lecture, Med. Times, Jan. 4, 1851. A series of papers on Tracheotomy by Dr. Turner, of Keith, are well worth reading, Prov. Med. Journal, 1854.

that the patient may have the benefit of the air that enters by the larynx. The surgeon should have several sizes. Those indicated in

the cut are the sizes made by Matthews. The tube depicted is the exact size of No. 4.

The next drawing represents a double tube, the outer of which is

reduced to two slips: by pressing these together its introduction is made easy.

The last improvement reduces the tube to two narrow blades, separable by means of a screw. The tube should be secured by a tape round the neck, as shown in the adjoining drawing of a patient of Mr. Partridge, in King's College Hospital: a boy aged five, whose trachea had been opened on account of the presence of a foreign body.

The throat should be carefully wrapped in a woollen comforter, and the air be made moist. M. Trousseau has

pointed out the important fact, that a difficulty of swallowing is liable to come on about the fourth or fifth day; and that it is expedient to give thickened soups, pounded meat, and other half-solid substances; liquids are then apt to enter the larynx, because the epiglottis is *out of gear*.

III. TRACHEOTOMY OR LARYNGOTOMY is required for any disease or injury which causes mechanical impediment to respiration.

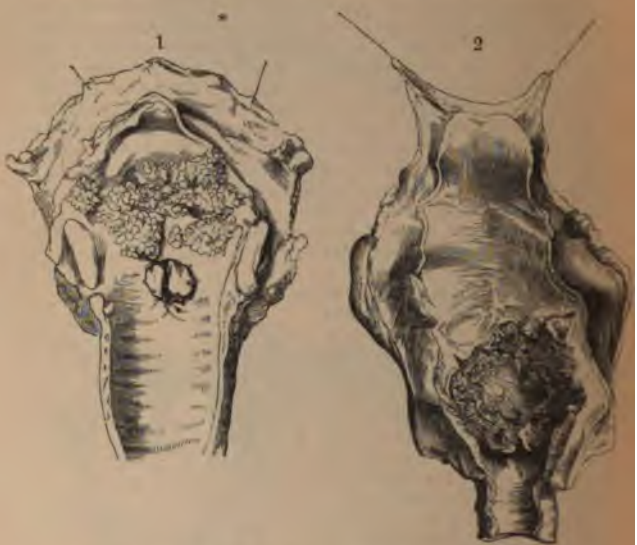
1. In acute *laryngitis*, *croup*, and *diphtheria*, when suffocation is imminent, tracheotomy should be performed. Some surgeons condemn it in croup, on the plea of its hopelessness. But we reply that is the only remedy; that it has undoubtedly in many cases prolonged a life which was on the verge of extinction; that it furnishes an exit for flakes of false membrane that cannot pass the rima glottidis; and that it very likely would be more successful if it were done earlier, without waiting till the patient is exhausted by struggling for breath. Moreover, Mr. Henry Smith has well shown that in some fatal cases of croup, the obstruction has been seated in the larynx only, and that an opening below would have saved life.

In the state called *œdema glottidis*, in which the submucous tissue about the glottis becomes infiltrated with serum in consequence of a low degree of inflammation, or of a general dropsical diathesis, a glance at the adjoining figure will show that laryngotomy must be often necessary to preserve life. This state may be suspected when intense dyspnœa, not referable to disease in the chest, and hoarseness arise, either during sore throat, or erysipelas, or after scarlet fever. It may be acute, or may be of slow origin and progress. Its extent may be determined by the laryngoscope. If acute, free purgation, free perspiration enforced by the vapour bath, leeches outwardly, and shallow scarifications or punctures of the tonsils, and of the epiglottis, and any other swelled structures that can be got at, are the first remedies: after these the solution of nitrate of silver; and, in any case, not to let a patient die suffocated, for want of laryngotomy. The œdema is more usually above than below the vocal cords.

2. In *chronic inflammation and ulceration of the larynx*, the operation should also be performed before the disease has lasted long enough to exhaust the patient by the suffocative cough, dyspnœa, and purulent expectoration which attend it. This is an occasional consequence of secondary syphilis, and more frequently of confirmed phthisis; but the

operation should always be performed if there is imminent danger of suffocation, even though the patient's ultimate recovery may be quite hopeless.

3. The operation is sometimes required for *tumours, warty excrescences, and epithelial growths within the larynx.* The symptoms are slowly increasing hoarseness, followed by loss of voice, tickling



cough, and noisy breathing; with purulent or bloody expectoration if ulceration occurs. The laryngoscope will confirm the diagnosis.

4. Tracheotomy was proposed nearly 20 years ago by Mr. Mayo, as a palliative in *hydrophobia.* It was afterwards proposed by Dr. Marshall Hall, in order to relieve or prevent the congestion within the head which may precede the severer *epileptic fits,* from the spasmodic closure of the rima glottidis. Experience has decided against the proposal in epilepsy,† and hydrophobia does not kill by suffocation.

* 1. Warty excrescences within the larynx. Laryngotomy has been performed. From the Middlesex Hospital Museum.—2. Ulceration of the larynx. Both cases probably epithelioma.

† See cases of failure, by Dr. Ogle and Dr. Ormerod, of Brighton, quoted in Ranking, vol. xxvii.

5. *Cases that simulate Laryngeal Disease.*—Some years since, the medical journals made themselves merry at the expense of the house-surgeon to one of the largest hospitals in London, who, being summoned in the night to a patient apparently dying of dyspnœa, immediately performed tracheotomy, but without avail; for the man expired very soon afterwards; and on a *post-mortem* examination it was found that there was nothing the matter with the larynx, but that a large aneurism existed on the arch of the aorta. What was the use, it was said, of cutting the throat of a man who was dying of aneurism? The house-surgeon, however, was not to blame, because, as is now very well known, tumours about the aortic arch may produce spasm of the glottis, by interfering with the recurrent nerves. But now that this fact is known, every surgeon should carefully scrutinise the chest in obscure cases of dyspnœa, to see whether it arise from this cause. No permanent good can then result from tracheotomy; yet the author heard of a case lately, at the Winchester Hospital, in which it certainly rescued a patient from immediate death, although he died shortly afterwards from other effects of the aneurism. But the operation is not admissible in that spasm of the glottis which often affects children during teething; nor yet in cases in which the symptoms of laryngitis are mimicked by hysteria.*

The laryngoscope will show the absence of disease of the larynx.

IV. Polypus of the Epiglottis, Larynx, and Trachea.—Professor Ehrman of Strasbourg collected the histories of thirty-one cases of polypus in these parts of the human subject, three in the cow, and two in the horse, in an interesting monograph. The early symptoms are hoarseness, and perhaps loss of voice, especially if the tumour be situated near the chordæ vocales; cough of a croupy, suffocative character; sense of obstruction in breathing, speaking, or swallowing; dyspnœa, gradually increasing with the growth of the tumour, next coming in terrific fits of suffocation, at last fatal: when the tumour, if within the trachea, is driven up between the chordæ vocales by expiration; or if attached to the epiglottis, is drawn down by inspiration. The most distinctive symptom is a valvular flapping sound heard or felt when the tumour moves during respiration. In more than one case the tumour, or a portion of it, has been torn off and coughed up: this of course decides the diagnosis. In a case by Mr. Stallard, the tumour was detached within the trachea, and the patient died suffocated. Polypi here, as elsewhere, are usually fibro-cellular, fibro-plastic, or epithelial. The laryngoscope here substitutes sight for faith. Instead of inferring that a tumour probably exists, the surgeon may see that it does.†

* *Coxeter's Laryngeal Syringe*, for introducing a few drops of caustic solution into the larynx, is a good substitute for the pencil.

† Histoire des Polypes des Larynx. Strasburgh, 1850; Case by Mr. Stallard, Med. Gaz., 19th May, 1843. There is a preparation of it in the King's College Museum from Mr. Mayo's collection. Dr. Gibb has collected a list of thirty other preparations in museums, of laryngeal growths and excrescences. On Throat and Windpipe, 2nd edition.

In a case which occurred to Professor Ehrman, the patient, a healthy woman, æt. 33, had lost her voice for three years; when she began to experience a sensation as of the opening and shutting of a valve in the larynx; violent cough came on occasionally during swallowing, and caused expectoration of small portions of tissue. She was suddenly seized with a fit of suffocation, almost fatal, when Professor Ehrman performed tracheotomy, and the next day extended the incision upwards, through the junction of the alæ of the thyroid cartilage, and removed a cauliflower excrescence from the left vocal cord. Recovery was complete, except of the voice. Seven months afterwards the patient unfortunately died of typhoid fever. The tumour was epithelioma, and had just begun to sprout again when the patient died. In another case, Dr. Brauers, of Louvain, laid open the larynx and cauterized a warty excrescence with acid nitrate of mercury and actual cautery. Final result not stated.

The laryngoscope, however, enables the practitioner to detect the presence of tumours, whether attached to the epiglottis, to vocal cords, true or false, or any neighbouring part; and in many instances to remove them. This will be the easier if pendulous and having a narrow neck, for then they may be snared and cut off with an écraseur; the same in principle as Sir W. R. Wilde's snare for polypi of the ear. Dr. Moura Bourdillon has devised a clever écraseur, with which he perforates the tumour, and holds it fast whilst it is being cut off, so that it shall not fall into the trachea, although, if it should, it will, says Dr. Gibb, be readily expectorated. The honour of first having removed a laryngeal tumour belongs to Dr. Walker, of Peterborough, who performed the operation on 18th August, 1861. Dr. Gibb followed, in November, 1862. If the tumour have a broad base, and cannot be snared, it may be gradually destroyed by touches with solid nitrate of silver.

Lastly, it may be observed that the operation of true laryngotomy, *i. e.*, division of the alæ of the thyroid at the middle line, may be practised in any case where it shall be judged expedient; and may be combined into a transverse incision for turning back one of those alæ, so as to submit the affected parts to direct treatment.

V. FRACTURES OF THE OS HYOIDES OR OF THE THYROID CARTILAGE are rare accidents, which may be produced by blows or falls on the front of the throat. The symptoms are pain; displacement of the fragments, ascertained by examination; difficulty of swallowing or of breathing; and perhaps hæmorrhage from the mucous membrane, which may be lacerated; perhaps emphysema. The treatment must depend on the urgency of the case. In a case of perpendicular fracture of the thyroid cartilage, seen by Dr. Gibb, the two lateral portions of the cartilage were separated at the pomum Adami; but the only symptoms were loss of voice, and an "indescribable sensation" in the throat.* In a case of fracture of the hyoid bone, the mouth was

* The author has to thank Dr. Gibb for the following references:—Dr. Gibb's case, Brit. Amer. Med. Journ., Montreal, vol. vi., p. 306; Cases of Fracture of

kept open by a gag, whilst the fragments, which had been displaced, and had even pierced the mucous membrane of the fauces, were restored to their proper position. Ice may be applied outwardly if hæmorrhage is very profuse, or inflammation violent. The trachea must be opened if requisite to provide for breathing, and the stomach-pump if the patient cannot swallow.

VI. SCALDS OF THE GLOTTIS, through swallowing boiling water or corrosive fluids, produce the ordinary symptoms of laryngitis—suffocative cough, and dyspnœa.

Treatment.—Leeches, ice to the throat, opiates or chloroform to tranquillize, and tracheotomy if required.

VII. HANGING may destroy life in three ways. 1. By dislocating the neck. 2. By compressing the trachea, and suspending respiration. 3. By compressing the jugular veins, and inducing apoplexy.

Treatment.—Artificial respiration, bleeding from the jugular vein if the face be turgid, dashing cold water on the face and chest, and a current of galvanism passed from the nape of the neck to the pit of the stomach, so as to excite the diaphragm.*

VIII. DROWNING, *Treatment of.*—Let the head hang down for *two seconds*, to let any water run out of the mouth: then lay down the body with the head raised; put two fingers into the mouth and draw the tongue well forwards; wipe out the mouth and throat; strip off wet clothes; wipe the face, nose, and eyes dry; and set people at work to rub the rest of the body dry. If breathing has nearly but not quite ceased, endeavour to rouse the circulation and the respiratory acts by friction of the entire surface, occasionally dashing cold water on the face, neck, and chest, and then wiping quite dry with a warm towel; and by tickling the nose and fauces, to excite sneezing, coughing, or vomiting.

If breathing should not be thoroughly restored by these means, it should be set to work artificially.

In some cases it may be expedient to draw blood from the arm, or jugular vein, in order to lessen the load of the heart; and this operation (or leeches) may be required for congestion of the head or chest, after the immediate peril has passed away.

Enemata of brandy may be of service in the early stage, whilst the heart's action is faltering. Hot bottles should be put between the thighs and under the axillæ, and the temperature of the limbs be maintained by hot flannels, &c.

A case is related in which life was restored by the most persevering friction, which was kept up for eight hours before the humanity of the

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Hyoid Bone, Amer. Journ. Med. Sc., Philadelphia, vol. xiii., 1833, p. 250; Stethoscope, Richmond. Vir. U. S., June, 1855; Pathological Trans., vol. i., p. 199; Fracture of Thyroid Cartilage, Brit. and For. Med. Rev., N.S., vol. viii., p. 272. See also Gibb, on Throat, 2nd edition.

* For the manner of applying galvanism in these cases refer to Part V., Chap. II.

surgeon, Dr. Douglass of Havre, was rewarded by a return of respiration.*

IX. ARTIFICIAL BREATHING is required in all cases of suspended animation, whether from drowning, injury, noxious gases, chloroform, or narcotic poisons. It may be performed by passing a pipe through the mouth, or a male catheter through the nostril, into the glottis; or by simply putting a pipe into one nostril, and closing the mouth and the other nostril, and blowing through it. But it is a better plan to use a small pair of bellows, putting its muzzle into one nostril. The operator should be careful to force the air into the lungs with very great gentleness, and to press the larynx against the spine, so that the air may not go down the œsophagus. If the larynx has been crushed by a rope, or by a violent blow, it may be necessary to perform tracheotomy, so as to impel a current of air directly into the trachea.

Or, instead of forcing air *into* the lungs, the operator may employ Dr. Sylvester's method, of imitating the natural expansion of the chest by muscular effort.† The patient is laid on his back with the shoulders raised; the tongue brought forward, and retained, if necessary, by gently closing the patient's teeth in it. Then the operator raises the patient's arms by the side of his head, and extends them gently and steadily upwards and forwards for a few minutes. This action imitates inspiration. Then the patient's arms are turned down, and gently and firmly pressed for a moment against the sides of the chest: this imitates a deep expiration. These actions should be perseveringly repeated about fifteen times in a minute.

SECTION IV.—SURGICAL AFFECTIONS OF THE EXTERNAL PARTS OF THE NECK AND THROAT.

I. WOUNDS OF THE THROAT are generally made with intention of suicide, and are extremely dangerous, no less from the importance of the parts injured, than from the despondency of the patient.

Treatment.—The general indications are, 1st, to arrest hæmorrhage; 2ndly, to obviate difficulty of breathing; 3rdly, to prevent inflammation of the trachea or chest.

In the first place, any arteries that are wounded must be tied, and hæmorrhage from large veins must be restrained by pressure with the finger, kept up as long as may be necessary. The patient should be put to bed in rather a warm room; and so soon as all oozing has ceased, but not before, his shoulders should be raised by pillows, and head be bent forwards, and be confined by a bandage passing from each side of the nightcap to the shoulders. Plasters are inadmissible, and so are sutures, except in the cases that will be alluded to

* Med. Gaz., 23rd December, 1846.

† The True Physiological Method of restoring persons apparently drowned or dead, and of resuscitating still-born children, by H. Sylvester, M.D. Lond., 1859. There is a rolling method, invented by the late Dr. Marshall Hall, very ingenious, but coarse and inefficient by the side of Dr. Sylvester's.

presently. If the wound penetrates the trachea or larynx, it should be covered with a loose woollen comforter, or a layer of cotton wool, or, after the first week, with one of Jeffreys' respirators, if it can be nicely adapted. The patient should not be kept too low; and if the pharynx or œsophagus is wounded, should be fed by a common, large-sized, elastic tube and bottle. But if during the inflammatory stage the attempt causes great irritation, it may be necessary to employ nutrient enemata merely. At all events, no tube should be passed through the wound for that purpose. The great thirst and dryness of the fauces, experienced in these cases, may in some measure be mitigated by sucking a wet rag, or, still better, a lump of Wenham Lake ice. If the patient find great difficulty in expectorating through the wound, he must be taught to close it partially by leaning his head forwards, and placing his fingers on it, whilst he makes an expiratory effort, so that he may expel the air with a sudden gust.

In every stage of the cure, difficulty of breathing should be viewed with suspicion. It may arise from several causes. 1. If the wound is above the larynx, it may be caused by the epiglottis being detached from the tongue, and hanging down upon or irritating the *rima glottidis*, or by clots of blood collecting in the pharynx. 2. It may be caused by an irregular and jagged division of the larynx or trachea, so that some pieces of the cartilage hang into the tube; or supposing the trachea to have been completely cut through, it may be caused by the aperture of the lower portion being overlapped by the upper. In these cases it may be requisite to employ sutures, but they should be passed merely through the cellular tissue around the cartilage, and neither through the cartilage nor the skin. 3. It may be caused by swelling of the mucous membrane of the larynx and trachea in the acute inflammatory stage immediately after the injury; or by chronic thickening of that membrane from the continued irritation of cold air, if the wound is very slow in closing. In the former of these cases, free antiphlogistic measures must be used; the latter must be prevented by using a proper position, so as to promote the approximation of the wound whilst it is healing. In either case it may be necessary to make a longitudinal division of the trachea to relieve the dyspnœa. 4. Another frequent cause of dyspnœa is the passage of blood into the trachea, if the wound is prematurely closed, and especially if it is sewn up or covered with plasters. Even supposing the trachea not to be opened, great danger may result from closing a wound of the throat before bleeding has ceased, for the blood may accumulate in the cellular tissue, and coagulate, and compress the trachea.

II. BRONCHOCELE (*Goître, Derbyshire neck*) signifies an hypertrophy of the thyroid gland.

There are two varieties: the *common*, which appears due to some qualities of air and water; the *exophthalmic*, due to nervous exhaustion.

1. *Common Goître.—Symptoms.*—A soft, projecting, elastic tumour

occupies the front of the neck, in the situation and of the shape of the thyroid gland. It is rarely tender, and the skin is not discoloured. Frequently one lateral lobe is larger than the other; and occasionally the middle lobe or isthmus is solely or principally affected.

Consequences.—When of moderate bulk, it rarely causes any inconvenience, except occasional headache, and difficulty of breathing in a stooping posture. But when very large, it may produce a most dangerous difficulty of swallowing and breathing, and congestion in the head by its pressure on the trachea, œsophagus, and jugular veins;† or it may induce thickening and disease of the trachea, with most obstinate cough, which may end in consumption.

Prognosis.—If it be soft and recent, and occur in a young patient, it will most likely be cured; but probably not if it be old, hard, and the patient advanced in life.

Anatomy.—The disease begins, probably, with hypertrophy of the natural gland structure, and concurrent formation of cysts. The gland structure nearly resembles that of the secretory glands; that is to say, consists of pouches of pellucid membrane, containing nuclei and nucleated cells; although not provided, like the secretory glands, with ducts. The cysts are developed in the interstices of the gland structure, and often have growths of it sprouting from their walls. Some cysts attain large size, and are filled with glairy matter, more or less solid: in very old cases earthy deposit may be formed. Other cysts which contain blood, or a bloody liquid, are probably the remains of dilated veins.‡ (See pp. 107, 351.)

Causes.—Bronchocele is what is termed an *endemic* disease: that

* From the King's College collection. The œsophagus is seen to be pushed to the right side by the tumour.

† Mr. Howship gives a case of bronchocele with the jugular vein passing through its substance. The patient suffered greatly from congestion in the head.

‡ Vide Baillie's Morbid Anatomy, by Wardrop, 2nd ed., p. 84, and Turner's Art of Surg., vol. i., p. 198. The second cut exhibits a preparation in the Middlesex Hospital Museum. The tumour is full of earthy deposit.

is, one peculiarly belonging to certain *places;* amongst which may be mentioned Derbyshire, Nottingham, and the chalky parts of England generally; and various Alpine and mountainous districts, especially the Tyrol and valley of the Rhone. The use of melted snow; or of water impregnated with calcareous or earthy particles, to which the inhabitants of all those places are more or less habituated, although not perhaps the invariable cause, is the most probable that can be assigned.* Most persons who are subject to it always find it increase when their health and strength are lowered; and in countries where it is endemic, it is closely associated with cretinism and idiocy. Therefore it is to be looked on as a disease of low degenerative type, and treated accordingly.

2. *The exophthalmic goitre* (disease of Dr. Graves, or of Basedow, who first called attention to it,) is a combination of mal-assimilation, excited action of the heart, throbbing of the arteries, loud whirring so-called *anæmic* purr during the systole of heart and arteries, and in the veins, and nervous excitation, with goitre, and protruded eyeballs. This disease seems to be induced solely by causes that depress the nervous system, without any reference to air or water. The eyeballs may be returned into their place by gentle pressure with the fingers. There is no doubt but that the conditions which give rise to this variety of goitre greatly contribute to the other. Both are most frequent in women, or in men of very nervous and hysterical character. In women, they are often associated with ovarian or sexual disturbance, and with that deep colouration of the eyelids which accompanies it.

Treatment.—The best remedy for the endemic bronchocele is iodine, combined with iodide of potassium to render it soluble, as in the compound tincture of the London Pharmacopœia, and given in such doses as not to cause pain or disorder of the stomach or the general health. (F. 88.) A lotion of iodine with iodide of potassium, may also be applied to the tumour; but it must be remembered that the swelling generally enlarges, instead of decreasing, if the skin be irritated. The patient, if possible, should remove from a district in which the malady is prevalent, and should drink boiled or distilled water. A residence on

* Capt. Alexander Gerard, in his account of Korrawur in the Himalayas, says, that "although the Korrawurrees can get nothing but snow for some months in the year, they are not so subject to goitres as the people that live in the damp grounds in the forest at the foot of the hills, where there can never be any snow water."

the coast, and warm sea-bathing, are mostly advantageous. Particular attention should be paid to the mental condition, to the uterine function, the appetite and digestion, the sleep, and the state of the heart; and steel with aloetic purgatives, or contrariwise, conium, valerian, and remedies that abate nervous excitement, with good diet, and country air, should be advised. This last plan of treatment (without iodine) is applicable to the exophthalmic cases.*

Instead of iodine, the burnt sponge, the bromides of potassium and of iron; chlorides of barium and calcium; iron; solution of potass or soda; digitalis, hyoscyamus, and belladonna; and sea-water, have been used.

If medicine proves ineffectual, and the tumour enlarges rapidly, so as to threaten suffocation or apoplexy, surgical operations must be resorted to, but not otherwise. There are three which have been proposed and practised:—viz., the introduction of setons; ligature of the arteries which supply the gland; and extirpation. The general results of these operations may be stated thus:—All three of them have at different times succeeded; all of them are hazardous to life, and have proved fatal; and the first two have, in some instances, failed to remove the disease, although the patient has recovered with his life.

If a *seton* be passed, it should be of silk, and large enough to fill the wound made by the needle, so that there may be no fear of bleeding. The needle should be long and narrow. If after the seton has remained for some time, it ceases to produce a diminution of the gland, it should be withdrawn, and be reintroduced in another place.

Extirpation of the gland is performed by making an incision in the middle line of the neck; the skin and muscles must then be dissected from the tumour; and every artery be tied as soon as it is divided. Then (as it is mostly enlargement of the isthmus, or middle lobe, that requires this operation), a strong double ligature should be passed through it, and should be firmly tied on each side of it, before it is cut out.

Encysted Tumour.—The *cysts*, which are formed in this gland, and which contain a glairy matter or blood, often require treatment. If necessary, they may be punctured, when they will most likely inflame, suppurate, or lose their lining membrane by sloughing, and contract. If this does not answer a seton should be passed. They are apt, after puncture, to give exit to a great quantity of arterial blood; if this prove troublesome, the wound must be filled with lint, when it will readily cease. In a case of cyst in the thyroid gland, which occurred to Mr. Fergusson, he could distinctly feel something of atheromatous consistence within it. An incision having been made, this turned out to be a cauliflower intracystic growth, so extremely vascular, that the wound was obliged to be closed. Similar

* For a capital account of the exophthalmic goître, see a paper by Dr. J. O. Fletcher, of Manchester, Brit. Med. Journ. for 1863, vol. i., p. 529.

cysts are liable to form in other parts of the neck, not connected with the thyroid gland. Their treatment is the same.*

This gland may further be affected with acute and chronic *inflammation*, and "tubercular" deposit; either of which may lead to abscess. Their *treatment* must be conducted on general principles.

It has also been affected with cancer, although rarely. Some cases of it are recorded in the Med. Chir. Trans., vol. xxvii., by Mr. Cæsar Hawkins, and by Mr. Brown, of Bath. The patients presented solid tumours in the situation of the gland, not having the characters of ordinary bronchocele; and one distinctive feature was the fixity of the parts.

III. HERNIA BRONCHALIS (*Bronchocele vera, Goitre aërien*) is a very rare tumour, formed by a protrusion of the mucous membrane through the cartilages of the larynx or the rings of the trachea, and caused by violent exertions of the voice. Larrey met with sundry instances of it in French officers, and in the muezzin or priests that call the people to prayer from the minarets in Mohammedan countries. The tumour is soft and elastic, can often be made to disappear by pressure, and is increased by any exertion. The only available treatment is moderate support.†

IV. PAROTID TUMOURS.—This name may be assigned to those tumours which occur in front of the ear, over the parotid gland. Cysts of various sorts, filled with glairy matter, or with blood; enchondromatous tumours, pure, or mixed with newly-developed gland tissue, and enlarged lymphatic glands, are the commonest; cancer may also be met with. Such tumours may of course involve the facial nerve; the facial artery, or the external carotid; or may extend inwards to the pterygoid and styloid processes. "If there be reason to suspect," says Mr. Liston, "that the disease is of a malignant nature, and not thoroughly limited by a cellular cyst, no interference is admissible. If, on the contrary, it be at all moveable, has advanced slowly, possesses a smooth surface, and is firm (neither of stony hardness, nor pulpy), then an operation may be contemplated." If slowness of growth and capability of being *moved freely* concur, the surgeon should remove such tumours; keeping his knife close to the tumour, especially at its deep part, so that he may not divide the nerve or artery, if possible. Sometimes, however, they may be so involved, that their division is unavoidable. The patient should always, therefore, be warned of the possibility of facial paralysis after removal of one of these tumours.

V. TUMOURS IN THE SIDE OF THE NECK.—Every variety of tumour may be found in this locality; enlarged lymphatic glands; cysts serous and sanguinolent; tumours composed of gland structure, like that of the thyroid gland; fibroplastic tumours, and cancer; the

* Vide a paper by Mr. B. Phillips in Med. Chir. Trans., vol. xxv., on Tumours in the Neck not involving the Thyroid Gland; Paget, Lectures, vol. ii.; Fergusson, Pract. Surg., 3rd edit., p. 655.

† Larrey, Clinique Chirurgicale, tom. ii., p. 81. Paris, 1829.

last possibly involving the great vessels, or attached to the vertebræ. If subjacent to the skin merely, and freely moveable on the subjacent tissues, they may readily be removed; but if they lie deep, and are bound down by the platysma and fascia, they require some consideration. If a tumour be of slow growth, defined in its outline, and moveable, so that it be probably not cancer, or if it interferes with deglutition or respiration, its extirpation may be attempted. If any suspicious tumour be of recent origin, the surgeon should wait, to see whether rapidity of growth and implication of adjacent parts give reason for believing it to be cancerous. See the remarks on the removal of tumours in Part V.

VI. WRYNECK is a peculiar distortion in which the head is bent down towards one shoulder (generally the right), and the face is turned to the opposite. The right eyebrow and right corner of the mouth generally become elevated, so as to preserve their horizontal position, notwithstanding the distortion of the neck.

Varieties.—This affection presents many varieties. It may perhaps be only a part of general lateral curvature of the spine. Or, 2, it may depend on caries of the cervical vertebræ. 3, It may be caused by contraction of the cicatrix of a burn or ulcer. Or, 4, by glandular enlargement on one side of the neck; the treatment of which cases requires no observation in this place.

But the genuine wryneck is produced by contraction of one sterno-mastoid muscle, which may depend, 1, on *inflammatory* or rheumatic *spasm* of that muscle. This form generally occurs somewhat suddenly to weakly children with disordered digestive organs. The writer has seen it as one of the kinds of rheumatic affections which follow scarlet fever. The muscle is hot and tender, and any motion causes pain.

Treatment.—Perfect rest in the horizontal posture, and poultices, or hot fomentations, so as to keep the skin constantly moist and perspirable, with purgatives and carbonate of ammonia, followed by bark with carbonate of ammonia, warm salt baths, and good diet.*

2. It may depend on *rigidity and atrophy* of the muscle, which may be a sequel of the state of inflammatory spasm last described, or may be congenital.

Treatment.—The use of a machine to keep up extension, may be of service in cases that are of no very long duration. If it fail, as it probably will, or if the case be congenital, division of the sternal origin of the muscle (or perhaps of the clavicular also) is the last resource. It is best performed thus:—The skin covering the muscle at about an inch from the sternum is to be pinched up between the left forefinger and thumb. A narrow curved bistoury is then to be thrust under the muscle, and is to be made to divide it as it is being withdrawn; but the wound in the skin must only be large enough to admit the instrument. The aperture may be made at the anterior border of the right

* For further information respecting this form of wryneck, consult Abernethy, Lecture xxxii.; James on Inflammation, 2nd ed., p. 484; Brodie on Local Nervous Affections; and Coley, Med. Gaz., N. S., vol. iv., p. 145.

muscle, and between the sternal and clavicular portions of the left. So soon as the division is complete, the ends of the muscle retract with a dull snap, and the thumb should be pressed on the part, to prevent effusion of blood under the skin. When the wound is healed, but not before, an apparatus should be applied to elongate the callus, and restore the neck to its proper position. Dr. Little finds that the best way of getting a purchase on the head, so as to keep it in a proper position, is by encircling it round the forehead and occiput with a broad strip of adhesive plaster, and with a bandage over this. Another strip of plaster is put round the waist. A tape is then sewn firmly to the bandage and plaster which encircle the head, either in front of or behind the ear, according to circumstances, and should be made to pass diagonally across the neck and chest, and be fastened to the waistband on the opposite side, with the requisite degree of tightness to insure proper rotation of the head. In cases of voluntary retention of the head on one side, Dr. Little has resorted, with advantage, to painful counter-irritation on the other.*

3. Lastly, this distortion may be caused by *palsy* of one sterno-mastoid muscle, in consequence of which, the other muscle, being uncontrolled, drags the neck permanently to its own side. If the administration of remedies calculated to remove any existing disease in the head or back, and to improve the health, and if strychnine, blisters, and electricity fail, division of the sound muscle has been recommended.†

CHAPTER XVI.

SURGICAL DISEASES AND INJURIES OF THE CHEST.

I. PNEUMOTHORAX signifies a distension of the cavity of the pleura with air, and collapse of the lung. It is known by the following symptoms:—On the affected side there is an absence of the respiratory murmur, with an exceedingly clear sound on percussion, and immobility of the ribs; and there is *puerile respiration* on the other side. It may be caused, 1, by a fractured rib which has lacerated the lung—and in this case it is attended with emphysema, as has been detailed at p. 271. 2. It may be caused by the bursting of an abscess of the lung into the cavity of the pleura, or by ulceration of the surface. This, if not preceded, is almost sure to be followed by pleurisy with serous effusion. This will be indicated by *succussion* and by *metallic tinkling*, in addition to the signs mentioned above. *Succus-*

* Little on Deformities, Lond. 1853.

† Vide Cases of Wryneck, &c., by Dieffenbach, in the Lancet for Sept. 1838. Gooch gives a case of wryneck and distortion of the jaw caused by contraction of the platysma myoides, and cured by division of that muscle, in the year 1759.

sion simply consists in shaking the patient, when (inasmuch as both air and fluid have escaped from the lung into the pleural cavity) the fluid will be heard to splash, if the ear is applied to the chest at the level of the fluid. If there is fluid in the cavity of the pleura and air besides, the clearest parts on percussion will always be uppermost, in whatever posture the patient may be. The *metallic tinkling* is a clear sound, like the dropping of water into a cask. It is produced when the patient coughs, by which means a drop of fluid is shaken from the orifice in the lung, and made to fall to the bottom of the chest. 3. It may be a consequence of the escape of air from a wounded lung, after the external wound through the parietes of the chest has been closed.

Treatment.—So far as the mere surgical treatment of this symptom is concerned, if the breathing become very difficult, with a distended and tympanitic condition of the diseased or injured side of the chest, a small trocar may be introduced between the fifth and sixth ribs, to let the air escape.

II. HÆMOTHORAX, which signifies the presence of blood in the pleural cavity, may be suspected if great dyspnœa and dulness on percussion follow a fractured rib, or if it come on rapidly after closure of a wound in the chest. The blood may proceed either from the intercostal artery, or from the lung.

Treatment.—If the difficulty of breathing be very urgent, a puncture must be made to let the blood escape.

III. HYDROTHORAX, or dropsy of the chest, is indicated by great difficulty of breathing, especially on lying down—livid countenance—disturbed sleep—dulness on percussion. It is usually a sequel of disease of the heart.

IV. EMPYEMA signifies abscess of the chest, or suppuration of the pleura. It is an effect of inflammation, whether idiopathic, or caused by injury; or else of the bursting of abscesses of the lung, in which case it will be accompanied with pneumothorax, or of the bursting of abscess in the vicinity. The *signs* are enlargement of the side of the chest—separation of the ribs—dyspnœa—difficulty of lying on the sound side—heart displaced to the right side, if the effusion be on the left.

V. PARACENTESIS.—There are three cases in which it may be expedient to withdraw the fluid from the pleura. First, a patient after an attack of phthisical pleurisy may go on for months with a large collection of serum in the cavity. The health improves up to a certain point; but the fluid remains unabsorbed, and the breathing is too limited for any useful purpose of life. Secondly, the effusion may be so great as to threaten death by asphyxia. Thirdly, the liquid, instead of being noxious by its bulk, may be so by its properties. There may be pain, and tendency to *point* at a particular spot; and there may be the shiverings and other *hectic* symptoms which indicate the absorption of decomposing pus. In either of these three cases an operation is expedient. The simplest operation is to puncture the skin between two ribs, say the fifth and sixth, where nearest the surface, that

is a little behind their middle, and thrust in a very fine trocar, to which an exhausting syringe is adapted. By this the liquid can be slowly pumped out of the chest, without the least risk of introducing air. Supposing the liquid merely serous or inodorous, when about a quart has been withdrawn the wound may be closed, and the operation repeated in a week. If the fluid extracted be offensive, the case must be treated like any other huge abscess. The boldest plan is to withdraw as much liquid as possible, and inject one or two pints of water, containing a drop of iodine in solution, repeating this process till the liquid returns inodorous. The puncture must be repeated at intervals. Should a permanent opening be established, it would be better to introduce a *drainage tube*. One sufficient aperture must be made. A long bent iron probe is passed through it, into the cavity, and made to project at one of the intercostal spaces, as far back and as low down as possible. Here it is to be felt and cut down upon, and made to project; and then a piece of silk to be attached to an eye in it, which is to be drawn through the wound, and by means of the silk, an India-rubber tube; the ends of the tube are tied together, and the pus allowed to drain away. But in any case, should the discharge be offensive, the iodine injection should be repeated.

VI. Hydrops Pericardii may occur under the same conditions as hydrothorax, and may be combined with it. Its diagnosis is obscure. It may be suspected to exist if the patient complain of constant weight in the præcordia, great dyspnœa, especially when lying on the back, and faintness upon exertion; if there is great dulness on percussion, and manifest fulness over the region of the heart—if its pulsations are tremulous—and the circulation embarrassed. The operation of *paracentesis pericardii* has been practised, although it can rarely be of much benefit, and ought not to be dreamed of until blisters and diuretics have failed entirely. It has been attempted in sundry cases of hydrothorax, which were mistaken for hydrops pericardii; but by a second lucky mistake the pleura was opened instead. It may be performed either by making an incision opposite the heart's apex, and dividing the muscles and pericardium with great precaution, or by first making an opening into the pleura, opposite the junction of the fifth or sixth rib with its cartilage—and then introducing the finger, feeling for the distended pericardium, and cutting into it with curved scissors; but it is an operation which we by no means recommend.

VII. Wounds and Contusions of the Parietes of the chest require the same treatment, whether the ribs are fractured or not. A bandage may be applied to prevent motion of the ribs, if the patient express himself relieved by it; but sometimes it adds to the distress, and must not be used. The bowels must be opened, the diet moderately low, cough and irritation be allayed by full opiates, and bleeding or leeches be employed, if necessary, to relieve difficult breathing and congestion of the lungs of a plethoric patient.

VIII. Penetrating Wounds of the thorax, such as stabs from a sword, are usually attended with wound of the lung, of which we shall

speak directly. In the dead body, when air is admitted to the cavity of the pleura, the lung collapses at once: this is certainly not the case in the living body, unless the external wound be very extensive indeed;—on the contrary, the lung continues to discharge its functions, although less perfectly in proportion to the amount of air passing in and out of the wound in the chest. The writer has had the opportunity of ascertaining that the respiratory murmur may be perfect throughout the lung, just after a wound in the pleural cavity has been closed.

Hernia of the Lung.—If the lung protrudes, the rule generally given is, to return it as quickly as possible, unless it is injured or beginning to mortify; but Mr. Guthrie recommends that it should be permitted to remain, as it closes the aperture into the pleura, and speedily granulates and heals over. Hernia of the lung, without external wound, protruding through the pleura amongst the muscles, is excessively rare, and must be treated by bandage or truss.

IX. WOUNDS OF THE LUNG, if extensive, are probably quickly fatal. If not, they will probably present the following symptoms:—Great dyspnœa and sense of suffocation; the countenance pallid and extremely anxious—and expectoration of blood, which is coughed up in florid arterial mouthfuls, mixed with occasional clots. If the wound is not extensive, there may be only a certain amount of oozing into the pleural cavity, and no cough nor bloody expectoration at all. Sometimes a violent blow causes hæmoptysis, though there be no actual wound of lung. The dangers of wounds of the chest are threefold. 1st. *Hæmorrhage*, which may destroy the patient by exhaustion, or may fill up the air passages and induce suffocation. 2ndly. *Inflammation*, which may supervene, and will be aggravated by the irritation of clots of blood, splintered bone, or of other extraneous bodies. 3rdly. Profuse and exhausting *suppuration*, with cough, debility, hectic, and all the symptoms of phthisis.

Treatment.—The first indication is to check the hæmorrhage. If this proceed from the intercostal, or any other artery of the parietes (although these do not often give trouble), the wound must be enlarged, and the bleeding orifice be seized with forceps, or tenaculum, or be secured by torsion.* If hæmorrhage proceed from the wounded lung, the remedies are ice or cold drinks, perfect quietude, opium to insure sleep and diminish the respiration, astringents, as gallic acid, or alum, administered internally.

Secondly, the wound should be quickly examined, and if it be of large size, or a gunshot wound, the finger should be introduced into it, to remove clots of blood, splinters of broken ribs, or any other foreign substances that it may readily find. If it is not sufficiently large for this purpose, it may be dilated by a probe-pointed bistoury.† At the same time, an intercostal artery, if wounded, should be secured.

* Mr. Lawson says that the intercostal artery was not once secured in the Crimean campaign.

† See also Dr. Fraser on Penetrating Wounds of the Chest.

Thirdly, the wound should then be accurately closed with sutures or lint and plaster, and the patient should be suffered to lie as quietly as possible. He should have plenty of cool air, and a very light covering. The rule is generally given, in all injuries of the thorax and abdomen, to place him on the wounded side; but he must decide for himself what position is the most comfortable. The closing of the wound is a great relief to dyspnœa. It is warmly advocated by the American surgeons.

Fourthly, inflammation must be combated; and all modern experience shows that this is best done by *gentle* treatment;—opium; aperients; ice; cool drinks and quiet;—venæsection rarely need be performed. The diet must be proportioned to the patient's condition: beef-tea, meat and port wine in one case; iced lemonade, barley-water, or milk and water in another. But, as Mr. Lawson observes, the inflammation which follows an injury is a totally different thing from idiopathic pneumonia.*

Fifthly, if there should be evidence that the side of the chest has become filled, and the lung compressed, by air, by extravasated blood, or by inflammatory effusion, serous or purulent, either the wound must be opened, or another incision should be made into the pleural cavity lower down.

Secondary hæmorrhage, after wounds of the lung, may, 1, be caused by inflammatory excitement; or, 2 (if the wound be gunshot), by the separation of sloughs from the lung; or, 3, by the sloughing of an intercostal artery that may have been brushed by the ball. Venæsection is the remedy for the first case, and the ligature, pressure, or styptics, such as gallic acid internally, for the latter two.

Foreign bodies in the chest add greatly to the danger of exhausting suppuration, although patients have recovered for years with balls, or pieces of cloth, encysted in the lung or pleural cavity. In some cases, a ball has remained rolling loosely about in the pleural cavity. If any foreign body is detected, it should, if possible, be removed, and part of the upper border of a rib may be sawn away with Hey's saw, if necessary, in order to get at it.

X. Abscess behind the sternum, and caries of that bone, sometimes require a perforation to be made in it with a trephine.†

XI. Wounds of the Heart generally prove fatal from hæmorrhage. Numerous instances, however, are on record, in which stabs or musket-wounds of this organ, have healed, both in man and animals, without any ill effects remaining. The diagnosis and prognosis will of course be extremely doubtful. The only available remedy is opium, in order to prevent hæmorrhage and keep the circulation as quiet as pos-

* See Chisholm's Military Surgery for the Confederate Army, 3rd edit., Columbia, 1864. Also Papers by Hamilton and others, Am. Med. Times, 1863 and 1864.

† For cases, references, &c., see G. Borlase Childs, Lancet, 24th Aug. 1850 Cæsar Hawkins, Med. Gaz. N.S., vol. v., p. 62.

sible, so that the blood may coagulate in the wound, and the coagulum become adherent and organised.

XII. DEFORMITY of the chest and spine is an almost inevitable consequence of severe pleurisy, or of empyema. The lung, compressed by pleuritic fluid, or bound down by adhesions, cannot expand again in the act of respiration, and the side of the chest falls in to accommodate itself to the crippled lung. These cases will be known by their history; by the fact that the deformity was preceded by enlargement; and by the deficient respiratory sounds which will be detected by auscultation. Mechanical appliances are of very questionable utility; but the writer has seen abundance of cases, in which, if the patient were young, and the disease not too severe and long-continued, great flattening and deformity have been completely recovered from by the unaided efforts of nature.

CHAPTER XVII.

INJURIES OF THE ABDOMEN, AND SURGICAL OPERATIONS.

I. PARACENTESIS ABDOMINIS, an operation much better called by the Anglo-Saxon term *tapping*, is required in *ascites*, and in *ovarian dropsy*, when the abdomen becomes so distended that the breathing and the circulation of the lower extremities are seriously impeded.

Diagnosis.—In the first place, *ascites* may be known by the abdomen being *equably* enlarged and fluctuating, not feeling harder at one part than at another; whilst in *ovarian dropsy*, the swelling probably fluctuates less distinctly, for it may be composed of distinct cysts, some of which feel more distended than others. If, however, the ovarian tumour consists of a single thin-walled cyst, this diagnostic mark will be absent. A second means of distinguishing the two affections is afforded by percussion. In ascites, the bowels, as they contain air, float up through the fluid; and, in whatever position the patient may be placed, they tend to occupy the uppermost part, and the fluid the lowest; and a clear sound may be elicited by percussion over the bowels, but a dull sound over the fluid. Thus, if the patient be placed on his back, a clear sound will be produced over the anterior surface of the abdominal parietes, but a dull sound towards the sides and back. In ovarian dropsy, on the contrary, the abdomen is distended by a tumour, which occupies its front part, the bowels being behind and on either side of it. Consequently, when the patient lies on her back, percussion of the anterior surface produces a dull sound; whilst a clear sound may be produced towards the back part and sides. Yet if the quantity of ascitic fluid be very large, and the abdomen be so distended that the mesentery does not allow the bowels to float up and entirely reach the anterior wall, it must be evident that this diagnostic mark may be far less palpable. Even in this case, however, the croaking of

air in the bowels may be perhaps felt; and as Dr. Tanner remarks, in some MS. notes with which he has favoured the author, it is more likely that ascites will be taken for ovarian dropsy than the converse. In any case of doubtful diagnosis, therefore, the probabilities are in favour of ascites. Some degree of ascites is frequently present with ovarian dropsy. Moreover, fluid may escape into the peritoneal cavity from the ovarian tumour, as stated by Hughes Bennett. Thirdly. A microscopic examination of the fluid which is removed will, in ovarian dropsy, most probably reveal the old disintegrated blood-globules, the epithelial cells, the large compound granular masses, and heaps of granules, oil-cells, and crystals of cholesterine, which abound in the liquid of old ovarian cysts.

Lastly, there are the history and general symptoms, the uterine derangement, and pelvic tumour felt in the early stage of the ovarian disease; the impaired health, œdema of the legs, and enlargement of the liver, which probably precede ascites. Into these it is not our province to enter.

Operation.—The rule generally given is, that the patient must be seated in a chair,—that a broad towel must be passed round the lower part of the abdomen, its ends to be crossed behind and intrusted to two assistants, who are to be instructed to draw it tight and support the belly as the fluid escapes. These precautions are taken, because of the risk that the removal of the compression to which the abdominal veins have been habituated, might cause the blood to gravitate into them from the heart and induce syncope, or that perhaps they might burst, and occasion a fatal hæmorrhage. But this risk is entirely avoided if the plan be adopted of placing the patient in the recumbent posture on her side, at the edge of the bed, and turning her over as the fluid escapes; and this plan is not only safer and more convenient, but more effectual for getting rid of the fluid. But be this as it may, the surgeon, holding a trocar in a canula in his right hand, with the end of his forefinger about two inches from the point of the instrument, plunges it through the linea alba, two inches below the umbilicus; then holding in the canula with his left hand, he pulls out the trocar with his right. Modern instruments are provided with an India-rubber tube at right angles; so that the fluid may pass into a convenient receptacle, without noise or splashing. Mr. Spencer Wells's syphon trocar has the additional advantage of permitting escape of fluid without the delay of withdrawing the trocar, a point of some

importance in tapping non-adherent ovarian cysts. If the trocar is a large one, which is expedient in ovarian dropsy, it will be as well, before introducing it, to puncture the skin with a common lancet. The aperture is afterwards to be closed with lint and plaster, and a broad bandage with napkins as a compress, to be applied with comfortable tightness. (See Bandages.) If a patient with ascites happens also to have an old irreducible hernia, and the sac is much distended, and preserves a free communication with the abdomen, it is a good plan to puncture the sac instead of the linea alba.

II. OVARIOTOMY.—The ovary, which, in a healthy condition, is about 1½ inch in its long diameter, and composed of peritonæal and fibrous coat, enclosing a vascular stroma filled with minute cysts, is liable to many diseases. Sometimes a solid tumour is developed in it, or a cutaneous cyst containing hair, teeth, and bone. But the disease to which the name ovarian tumour, or ovarian or encysted dropsy is given, may be described as an exaggeration of the entire organ, or of one or more of the individual cysts contained in it, into an enormous tumour, which may weigh from 50 to 100 lb., or even more. This tumour may be simple or cancerous.

In the simple, the parts composing the tumour are natural structures, only greatly hypertrophied; in the cancerous, the solid intracystic parts are composed of cancer tissue. In some cases a cancerous growth may be superadded to a previously-existing simple tumour.

The number of cysts may be one, or almost infinite, there being in the latter case a vast number of smaller ones developed in the interstices, and projecting into the cavities, of the larger ones. They may be thin and flexible like bladder, or thick and semicartilaginous. The contained fluid may be clear and transparent as pure water, or thick and ropy, from the presence of a peculiar extractive matter; or may be of a deep coffee colour from the presence of broken-down colouring matter of the blood; or opake, from the presence of the matters shown in the preceding page. The ovarian fluid contains much less albumen than blood serum does, and no phosphate of soda, or but very little.*

The *diagnosis* from ascites has been spoken of already. From pregnancy it must be distinguished by its history and duration, and especially by the physical condition of the uterus, as ascertained by examination. The diagnosis is sometimes more difficult than might be thought. Supposing a woman who has a right to be pregnant and believes herself so. There may be enough enlargement of breasts and stomach derangement, the menses may have been just so long absent, and the movement of a small hard cyst within a larger one may be so like the gravitation of the fœtus in utero as to deceive a careless practitioner. The state of the os uteri, the absence of the fœtal heart-sounds, and the duration of the case will, however, enlighten him. But for all those points we must refer to special writers, our concern being only with the treatment by operation.

* Analysis by Dr. G. O. Rees, quoted in Dr. A. Farre's article Uterus, in Todd's Cyclopædia.

Once in existence, three courses are open to this disease. 1. It may subside after tapping, or after accidental rupture of the cyst into the peritonæal cavity. The latter event, however, has proved fatal through peritonitis in most of the instances in which it has been noticed. In some cases relief, more or less great, has followed the ulceration of the tumour, and the discharge of its contents through the navel or into some part of the bowels. But each of these cases is rare.

2. The disease, although incurable, may remain stationary, the system become habituated to it, and life go on almost as though the burden existed not. The writer in former editions mentioned the case of a lady, aged about 60, of tall commanding figure, in whom an ovarian tumour, of immense size, has existed for more than thirty years. Her health had been for years pretty good, although when the disease first made its appearance, before the diagnosis was fully made out, she suffered for three years from all the remedies that the physicians of George the Fourth's time could devise for the dispersion of the swelling. Since the last edition she died of suppuration of the cyst.

3. But unhappily such cases as these are the exceptions. In by far the greater number the tumour continues to increase; fills up the abdomen; interferes with the breathing; makes the patient's existence a misery; and at last wears her out from pain and irritation, and especially from vomiting, which seems to set in when the tumour has reached its climax. Or the tumour may undergo degeneration and suppurate; and shiverings, hectic, and perspirations indicate absorption of noxious matter. Hæmorrhage from the uterus is of frequent occurrence in the advanced stages, and so far as the writer has observed, it should not be interfered with, unless very profuse. The fatal issue will be, of course, much quicker if the malady is of a cancerous nature; in which case, instead of remaining free and unattached in the peritonæal cavity, or even instead of being bound down by more or less numerous bands of adhesion, the tumour becomes amalgamated with the abdominal wall, with the liver, and with other viscera, and communicates a cancerous infiltration to every part that it adheres to. The question then is, what can our art do to cure the patient, or to mitigate her sufferings: and there are three things that require mention, viz., 1stly, tapping; 2ndly, various medical and surgical measures adopted in the hope of producing atrophy of the tumour; and, 3rdly, extirpation, or ovariotomy.

1. *Tapping.*—This is the simplest mode of procuring relief; and in some few cases the tumour, emptied by this means, continues quiescent for years or for life. But far more commonly the operation requires to be soon repeated. Cases are extant, in one of which the patient lived to be tapped 66 times at intervals of about a month; and, in another, 128 times at intervals of six weeks; but taken as a general rule, it may be affirmed that few patients survive more than four years after the first tapping. After the first operation, the patient feels quite well; but the fluid collects, say in six months. Then follows a second tapping; the patient remains pretty well for four months. Then a third,

which lasts for three months; and so on; the interval becomes shorter; the emaciation greater; other cysts enlarge, to reach which, it may be necessary to use a very long trocar, and to plunge it quite deeply, or the puncture must be in the linea semilunaris, or wherever fluctuation is most evident. Tapping *per vaginam*, when a fluctuating portion of tumour projects much in that situation, may be worth adopting. At last no more can be done. Vomiting is incessant; and delirium and exhaustion close the scene.

2. Under the second head may be enumerated an immense variety of plans for producing atrophy or absorption of the tumour; such as (*a*) the administration of the iodide of potassium, with tonics, and the iodide of iron: these should have a fair trial in incipient cases, and after tapping: in cases in which the author has been consulted, he has always found a tonic plan of treatment the most effectual. Considering the enormous amount of blood-cells, albumen, and other blood-stuff in the fluid contents of the tumour, the writer has suggested the administration of gallic acid and the other vegetable astringents. As for mercury and remedies whose object it is to promote absorption by creating great evacuations, or by lowering the system, the writer can only say that he believes the less they are resorted to the longer the patient will live. (*b*) Mr. Isaac Baker Brown's plan of first emptying the cyst by tapping, then applying firm pressure and administering mercury. (*c*) Operations for opening the cyst into the cavity of the peritonæum by subcutaneous section, thus imitating the cases in which the cyst has been ruptured by violent action of the abdominal muscles, and the fluid has been absorbed, and the patient cured. But of course, for the success of such operations, it is requisite that the active growth of the tumour be at an end. (*d*) Operations for causing the tumour to waste and suppurate by passing setons. (*e*) Procuring adhesion of the cyst to the abdominal parietes, and establishing an ulcerated opening into the cyst at the adherent spot; or cutting into the cyst, and stitching the edges of the opening into it to those of the wound through the abdominal parietes; thus establishing an *artificial oviduct*, through which the contents of the cyst may be evacuated. Most of these plans were originated by Mr. I. B. Brown. (*f*) The *iodine injection* has been tried by Dr. Simpson with good results; and by Mr. Spencer Wells. The latter gentleman prefers a solution of 20 grains of iodine and 30 of iodide of potassium, in an ounce of distilled water, to the strong tincture of the Edinburgh Pharmacopœia, which Dr. Simpson employs. About two fluid ounces of this solution are injected after the cyst has been completely emptied. The same precautions are necessary as in the injection of the tunica vaginalis, not to let the point of the trocar slip out of the cyst, so as to run the risk of injecting the fluid into the peritonæum. For this purpose a catheter may be passed through the canula of the trocar, deep into the cyst, before the fluid is let out, and be held there. The iodine is injected, or allowed to run in through a glass syringe, and is suffered to remain. If it answers the desired end, it will destroy or modify the inner surface of the sac, take

away its secreting power, and cause the cyst to wither. The pain which follows the injection may be relieved by opium, and fomentations. But it stands to reason that this is not a *radical* remedy, and that it is not a safe remedy, unless there be but one cyst. To ascertain the last point, Dr. Graily Hewitt uses an exploring sound, which may be passed into the interior of the cyst, through the canula of a trocar; which is provided with an india-rubber diaphragm to prevent the escape of the liquid, till the whole interior of the cyst has been explored.* (*g*) There is another operation of fair promise which was proposed by Dr. Tanner, for cases in which the presence of extensive adhesions renders it impossible to remove the cyst. This consists in tying tightly the pedicle of the tumour after the fluid has been removed by tapping. Thus it may be hoped, that whilst the supply of blood furnished to the cyst by its adhesions will be sufficient to prevent gangrene, the obstruction of the main arterial channel might prevent the fluid from being secreted anew.

3. *Ovariotomy.*—The remaining remedy is extirpation. But before describing the operation we must, as a part of the history of our profession, give an account of the objections which have been raised against it. Some of these were fair enough twenty years ago, and were raised in thorough good faith. The early difficulties and misadventures of ovariotomists appeared great; and it was fair enough to say, that although the disease did lead to a miserable death by itself, that this was no reason for submitting the patient to a cruel and hopeless operation. The increased skill in diagnosis, the improved details of treatment, nay, the general improvement of all surgery, have now done away with these objections in the minds of rational men. But our profession, like every other, contains a few persons whose bigotry and prejudice are invincible. They admit that they cannot themselves remove this burden on their fellow-creatures' lives, and yet, like the old Pharisees, they will not allow any one else to try. With minds thoroughly fossilized, incapable of making one advance in science themselves, their sole pleasure is to revile those who do; to excite odium against them; to use vituperative expressions, such as "belly-ripping," where argument fails; and to delight themselves in the miserable notoriety which they gain by their frantic attacks on scientific men. Such men continue to rail against ovariotomy, as they do against every other improvement. Let us, then, see what objections can now, or may have been formerly raised against ovariotomy.

They were threefold. First, the *difficulty of diagnosis*; as proofs of which used to be cited a number of cases in which the belly was laid open for what was no ovarian tumour at all. Secondly, the *impossibility*, in some cases, *of removing the tumour*, through adhesions, even though it were ovarian. Thirdly, the *mortality*. In support of these objections there used to be cited the case of four patients operated

* See remarks by Dr. Simpson quoted in Prov. Med. Journ., 1854, p. 1067; case by Spencer Wells, and description of Dr. Graily Hewitt's instrument, Med. Times, 1859, vol. i., p. 549.

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on by Mr. Lizars forty or fifty years ago, of whom one died; one recovered; in one, after the abdomen was laid open, there was found to be no tumour at all; and in the fourth there was discovered an enormous mass of convoluted vessels looking like a placenta, which proceeded from the omentum to the tumour, and of course rendered extirpation quite out of the question, so that the incision was closed again.* Without, however, reproducing here more of the older partial statistical summaries, let us quote from the very elaborate table draw up by Dr. Clay, in his Translation of Kiwisch on Diseases of the Ovaries, 1860.

Dr. Clay gives a total of 537 cases of ovariotomy attempted or completed. Of these, diagnosis was at fault in 36: and an analysis of these instructively shows the affections most likely to be mistaken for ovarian disease; 23 were uterine tumours, 2 mesenteric, 2 tubal fœtation, 2 omental, 1 splenic, 1 obesity and meteorism, 2 chronic inflammation and thickening of colon, &c., 2 no tumour at all, 1 not stated. In 13 of these *some* tumour was removed; in 23 the abdomen was closed without further operation.

In 82 cases, the *operation was abandoned through adhesions.* By summing up the recoveries and deaths in these cases, we see what mortality has been due to laying open a diseased abdomen simply, without removal of a tumour. Thus, of these 82 cases, 58 recovered and 24 died. Of the 23 non-ovarian cases of simply opened abdomen, 16 recovered, and 7 died.

In 24 cases there was *partial* excision of ovarian tumour. The complete excision was hindered by most close and extensive adhesions, or by a solid cancerous tumour. These are a fatal series; 14 died.

In 395 cases complete ovariotomy was performed; and of these 212 recovered and 183 died. The prevalent causes of death were shock, hæmorrhage, and peritonitis. A few died from tetanus and other complications.

Looking upon ovariotomy as embracing almost all the dangers of all surgical operations, it may be affirmed that it will participate in the general improvement which time brings. *Shock* will be mitigated by careful nourishment before the operation; by a gentle administration of chloroform; by a quick and dexterous operation, and by skill in mitigating symptoms afterwards. Operators are more on their guard against *hæmorrhage*, and more alive to its dangers. *Adhesions* are better dealt with than formerly. As for *peritonitis*, they are more than ever convinced that this is another word for chemical decomposition; for the results of unclean hospital air; for the intrusion of pus into the peritonæal cavity, or of the decomposing sanies of the stump of the pedicle. And whatever makes ovariotomy safer will make all other surgical operations so also. On behalf of the operation we say,

1st, That the mortality arising from this is not larger than that from many other surgical operations; and, to use the words of Mr. Southam, the statistical argument is singularly inconsistent when used

* Solly, in a Lecture in the Med. Gaz., vol. xxxviii. See Tilt, Lancet, 1848, vol. ii., p. 626.

by surgeons who do not hesitate to recommend operations still more dangerous, for the removal of diseases not immediately fatal; as, for example, ligature of the innominata artery for aneurism; an operation that always proved fatal till the year 1864. Out of 106 cases, Mr. Spencer Wells has preserved the lives of 70—a mortality of 1 in 3—a result more favourable than that of the larger amputations, herniotomy, or lithotomy in the adult. Dr. Clay, 110 operations, 76 recoveries. Mr. Baker Brown has performed complete ovariotomy in 68 cases, with 28 deaths and 40 recoveries. 2ndly, that no other plan of treatment can effect a radical cure, but that by this, according to Clay's tables, 23 women, relieved of a burden which made life miserable, have married and borne children. 3rdly, at any rate, there is one rule which ought in all fairness to be applied to the results of individual operators. One man esteems it a duty to give his patient a chance, though the case be an unpromising one; another selects only promising cases; still the average of two-thirds of recoveries is hopeful. 4thly, that if the surgeon, in order to complete his diagnosis, makes a small incision, to ascertain the existence of adhesions, and closes it again with suture if he finds this to be the case, no great harm is likely to result: in fact, this, which is sometimes raked up as an opprobrium against operators, is a perfectly justifiable measure. Lastly, that it is by far the *most merciful* plan of treatment, if adopted early, in patients otherwise healthy, with a still growing but nonadherent tumour.

In a field where so many have distinguished themselves, it would be impossible to mention all, and unfair to select a few of those who have acquired celebrity for their skill and success in this operation; yet the writer cannot refrain from adducing the names of Mr. Lane, Dr. Clay, Mr. Southam, Mr. Walne, Dr. Frederic Bird, Mr. Jeaffreson of Framlingham, Mr. West, Mr. Crouch of Bruton, Mr. I. B. Brown, Dr. Tanner, Mr. Hutchinson, Mr. Bryant, Dr. Tyler Smith, Dr. Keith, and Mr. Spencer Wells.

The surgeon who proposes to himself to perform this operation, should make certain, 1st, that a tumour exists, and that it is ovarian; 2ndly, that the tumour is increasing, and likely to destroy life, if allowed to remain. No one would interfere with a stationary tumour. 3rdly, that the increase of the tumour is not arrested by tapping, moderate pressure, and iodine or iron. One tapping is often expedient, as a means of diagnosis, because if the empty sac subsides into the pelvis, it is a guarantee against extensive adhesions. 4thly, that the disease is not cancerous. Cancer may be suspected if the tumour has begun early in life, is increasing very fast, and is adherent, and if there is great pain, and decay of health and strength. 5thly, that the general health is such as would be desired in any patient who was to undergo a capital operation; lastly, he should ascertain whether there are extensive adhesions to the abdominal parietes or viscera. This he may do in some measure by noticing whether the tumour shifts its place as the patient rolls herself from side to side, and also by a very ingenious test which the author has seen used by Dr. F. Bird; namely, by putting

the abdominal muscles in action, and noticing whether they rise much from the surface of the tumour. Thus, if the patient whilst lying on her back be told to raise herself up in her bed without using her arms, the recti muscles will start up into a prominent band, if their sheath is *not* bound down by adhesions on its peritoneal surface, but not if it is, unless the adhesions are long, or the cyst flaccid. By observing also, as Dr. Sibson suggests, whether the tumour descends during inspiration; and by grasping and endeavouring to slide the abdominal parietes over the tumour, or to grasp them and lift them from the tumour, much valuable information will be derived; but the decisive test is a short incision, and exploration with the finger.

The reasons for running the risk will be much the strongest in the case of a young healthy person, whose life, if spared, might be long and valuable.

The *operation* comprises the following steps. The patient ought to have the bowels and bladder empty, and to have taken food three hours previously. The temperature of the operation room should be raised to a degree comfortable to the patient; but the high temperatures and moist vapour of the earlier operators are no longer adopted. The patient's position should be easy, and chloroform should be administered. The most happy method of operating, supposing that the circumstances admit of it, is, to make a short incision, say from four to six inches, between the umbilicus and the pubes, along the linea alba, through the peritoneum. Next, to puncture the cyst, and empty it; and for this purpose to employ the large trocar with hooked canula, devised by Mr. Spencer Wells for rapidly emptying the cyst, seizing it, and withdrawing it without allowing any of the fluid to escape into the peritoneal cavity. In the next place, to separate the tumour from its pedicle, and secure the divided tissues, so that there shall be no internal bleeding, which is one great source of danger after the operation. At the same time it is one of the greatest modern improvements that the divided pedicle shall not be put back within the abdomen, where it may possibly bleed, and certainly suppurate before the ligatures separate; whilst the ligatures themselves keep the wound open, and

favour the spread of inflammation; but that it shall be brought out of the wound and be fixed there. This improvement is due to Mr. Duffin. For this purpose the pedicle may be compressed by a clamp, originally devised by Mr. Hutchinson, consisting, in the most improved form of the instrument, of two plates of steel, which are gilded, and are capable of being screwed so as to compress the pedicle thoroughly.* The inner surface of each plate is jagged, so that the pedicle can scarcely slip. It should, as Mr. Spencer Wells observes, be so placed as not to drag the uterus, and consequently should be as far from that organ as possible; and if the pedicle be very short, a portion of cyst may be cut off, sufficient to make a pedicle long enough to project through the wound. The latest form of clamp used by Mr. S. Wells is here depicted. It is more easily applied, more secure, and gives less annoyance to the patient than former models. Lastly, the wound is closed accurately (leaving the stump of the pedicle secured by the clamp just protruding from it), and so the operation is finished.

The method of closing the wound recommended by Mr. Spencer Wells is by a sufficient number of sutures of fine, strong, pure silk, which should be passed from within outwards through the entire thickness of the wound, including the peritonæum, so as to bring two surfaces of that membrane into contact, and produce adhesion of them, and exclude the contact of the purulent matter which may be secreted by the other structures.

But there are cases in which the steps of the operation do not follow so smoothly as we have just described them. The abdomen may contain a large quantity of ascitic fluid, most of which must be allowed to escape before beginning upon the ovary. It may not be possible to extract the tumour through a small incision, either because its contents are too viscid to run out, or because it is solid and cannot be emptied (of course any lesser contained cysts may be punctured), or because of adhesions. These, if old, firm, and extensive, may cause the operation to be abandoned; if slighter, they may be gently torn through, or, if need be, divided with the knife, and any arteries or veins of sufficient consequence must be tied. If it be impossible to apply the clamp, a stout whipcord ligature may be made to encircle the whole

* See Medical Times and Gazette, Dec. 11, 1858.

pedicle; and even then, some single vessels may require to be tied. The remaining ovary should be examined, and if diseased may be removed; but the patient should not needlessly be *spayed*. One steady assistant should take charge of the edges of the wound, holding them close to the cyst, so that the bowels shall not protrude between; flannels steeped in water at 98° should be at hand to protect them if need be.*

The patient should be kept thoroughly warm during the operation, by flannel stockings, and bottles of hot water to the feet; and the abdomen be afterwards padded with the softest cotton wool, and supported by a many-tailed or Indian bandage. Morphia may be administered in regular small doses, to procure sleep by night and ease by day. Sickness and thirst may be allayed by sucking ice. The diet should be good, consisting of soup, light pudding, and wine or brandy and soda water, according to the patient's taste. The bowels should be regulated as they are after a confinement; that is, having been well emptied before the operation, they need not be disturbed till they begin to feel uncomfortable; then a lavement may be administered. The catheter should be introduced regularly. If great pain and tenderness come on, a common warm linseed poultice may be applied, as suggested by Mr. Wells; and if serous effusion should be produced by peritonitis, he very rationally recommends that the wound should be partially opened to let it escape, as he did in one case, with the best possible results;—for, as he observes, the serum in this case was so acrid that it scalded the fingers; and there is no doubt but that it would have been capable by inoculation of producing puerperal fever: what mischief, then, must it not cause within the peritonæal cavity? Mr. Wells has also evacuated fluid from the pouch of peritonæum between uterus and rectum, by vaginal puncture, and in one case has left in a drainage-tube with excellent effect. (Med. Times and Gaz., July 1864.) Dr. Peaslee has reported three cases in which he has practised daily syringing of the peritonæal cavity with warm water, and injections of chloride of soda. The patients recovered. (American Journal Med. Science, July, 1864.)†

III. VIOLENT BLOWS ON THE ABDOMEN from obtuse substances,

* "The fatal mistakes of the operator are, leaving important blood-vessels unsecured; tearing any of the abdominal viscera inadvertently or in coarse haste to get through adhesions; uniting so badly the external wound that it opens and lets out the intestines; treating the gravid uterus as if it were an ovarian cyst; leaving blood or escaped fluid, or even instruments or sponges in the cavity of the abdomen; as is likely to happen when the operation is hurried to a close, the intestines shovelled back, and the external wound badly adjusted, under that precipitate dread of peritoneal exposure which is inculcated almost within the first week of dissecting-room life."—Dr. Savage, Lancet, 1864, vol. ii., p. 220.

† See Lizars on the Extirpation of Diseased Ovaria, Edinburgh, 1825; J. Hughes Bennett, Ed. Med. and Surg. Jour. April, 1846; B. Phillips, Med. Chir. Trans vol. xxvii.; Dr. R. Lee, on Ovarian and Uterine Diseases, Lond., 1853; Dr. Tilt, Lancet, 1849 and 1850; Mr. I. B. Brown, on Diseases of Women, Lond. 1854; Sontham on Ovariotomy, Prov. Journ. 1845, and Transactions, 1847; Dr. Tanner, in the Lancet for 1852, vol. ii., and Med. Times for 1853, vol. i.

the passage of cart-wheels, spent shot, and so forth, may produce various results. 1. They may cause severe *concussion* and collapse, which may either speedily prove fatal, or may pass off without further ill consequences, or may be succeeded by inflammation.

2. They may produce *laceration* of the bowels, or of the solid viscera; with effusion of blood or of their secretions into the peritoneal cavity. This may be suspected if the patient complains of excruciating pain radiating over the whole belly; if the features are pinched, the belly soon swells, and the pulse is very small and tremulous.

Treatment.—The patient must be suffered to lie quietly during the stage of collapse, without any officious administration of stimulants; and so soon as pain or vomiting comes on, he should have opium by enema. Subsequently leeches, and fomentations to the belly, to abate inflammation; and opium, to support the system under the irritation, are the only available remedies. The bowels should not be disturbed either with purgatives or enemata for the first three days, nor should any nutriment be taken, save very small quantities of ice, milk and water, or beef-tea, at intervals.

IV. ABSCESSES between the abdominal parietes occasionally result from contusions or punctured wounds, and sometimes occur idiopathically. According to the principles laid down in the chapter on Abscess, they should be opened early, both because of the tendinous structures by which they are covered, and of the possibility that they might burst into the peritonæum.

V. PENETRATING WOUNDS of the abdomen may be divided into four species; namely, 1st, simple wounds of the parietes; 2ndly, wounds of the viscera; 3rdly, wounds of the parietes with protrusion of the viscera; and, 4thly, wounds in which some of the viscera are protruded and wounded likewise.

1. In the case of a *simple wound of the parietes*, the surgeon must first (if it be large enough) gently introduce his finger, to ascertain that no part of the intestines is beginning to protrude; then the wound must be closed by suture, which should be passed deeply. If the epigastric artery is divided, it must be cut down upon and tied. The surgeon must recollect that when any part of the abdominal parietes has been wounded or severely bruised, it is almost certain afterwards to become the seat of hernial protrusion.

2. *Wounds of the viscera.*—In the case of small wounds of the abdomen without protrusion, it will be often impossible to say whether the bowels are wounded or not, but the treatment must be altogether the same, whether they are or not.

(*a*) Wounds of the *stomach* may be known by the situation and depth of the wound, by vomiting of blood, by the very great depression

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C. R. Thompson of Westerham (describes the improved trocar mentioned at p. 534), Med. Times, 1858, vol. i., p. 329; Spencer Wells in Med. Times and Gaz. 1858 and 1864; Dr. Clay in Obstet. Trans., vol. v., his 109th and 110th cases, Glasgow Medical Journal, Oct., 1864.

and collapse, and by the nature of the matters (if any) that escape from the wound.

(*b*) Wounds of the *bowels* may *perhaps* be known by the passage of blood with the stools, but certainly by fæcal matter escaping from the wound, or by the symptoms of extravasation of their contents into the abdominal cavity—that is to say, excruciating pain, radiating over the whole belly from the seat of the injury, and attended with signs of great collapse. Fortunately, however, as Mr. Travers has shown, wounds of the stomach and intestines, unless very large, are not so liable to be attended with extravasation as was formerly thought. For, in the first place, the mucous membrane protrudes through the muscular, so as to fill up a small aperture; and, secondly, any tendency to extravasation is counteracted by the constant equable pressure of all the abdominal viscera against each other. Moreover, lymph is soon effused, and glues the neighbouring parts together, and thus the aperture is circumscribed, and any future extravasation is prevented.

(*c*) Wounds of the *liver*, if extensive, are, from its great vascularity, nearly as fatal as those of the heart. Small wounds and lacerations may be recovered from. There will at first be symptoms of great collapse, which, if the patient survive, will be succeeded by severe sickness, pain in the liver, yellowness of the skin and urine, great itching, and a glairy, bilious discharge from the wound.

(*d*) Wounds or rupture of the *gall-bladder* are almost invariably fatal, although there are one or two instances of recovery on record.

(*e*) Wounds of the *spleen*, if deep, are also fatal, from the great hæmorrhage that follows, although the whole organ has been removed from animals, and from man, without much consequent evil.

(*f*) Wounds of the *kidneys* are attended with bloody urine. They are exceedingly dangerous, from hæmorrhage, next from violent inflammation with excessive vomiting; and lastly, from profuse suppuration, kept up by the passage of urine through the wound. Very mild laxatives, the warm bath, very light dressings, so as to admit of the flow of urine through the wound, and some unctuous application to prevent excoriation of the surrounding skin, are the necessary measures.

(*g*) Wounds of the *bladder*, if communicating with the peritonæum, are extremely dangerous, owing to extravasation of urine. In fact, unless there is an external wound through which it can escape, they are almost uniformly mortal. The catheter must be worn constantly. Mr. Syme (in his "Contributions") gives a case of rupture of the bladder, below the line of reflection of the peritonæum, in which the patient recovered, free incisions having been made to give exit to the urine which was extravasated between the abdominal muscles and skin.

3. *If the intestines protrude*, and are neither wounded nor gangrenous, they should first be freed from any foreign particles that stick to them, and then be returned as soon as possible. The patient should be placed on his back, with his shoulders raised, and his knees drawn up. If absolutely necessary, the wound must be a little dilated with

a probe-pointed bistoury. Then the surgeon should return the bowel portion by portion, passing it back with his right forefinger and thumb, and keeping his left forefinger on that which is already replaced, to prevent it from protruding again. He should be careful to replace intestine before omentum, and any wounded part should be returned last. The abdominal parietes are best sewn together as after ovariotomy

4. If the stomach and intestines, when *protruded, are found to be wounded*, the wound should be sewn up by a continuous or glover's suture (keeping the serous surfaces applied together, and turned inwards). (See p. 135.) Then it is hoped that the aperture in the bowel will be united by the adhesion of the contiguous serous surfaces; and the silk employed in the suture will be detached by ulceration, and fall into its cavity. If, however, any part of the bowel that is protruded be very much lacerated, or be gangrenous, it should not be returned, but be left hanging out, that an *artificial anus* may be formed.

The symptoms of *inflammation of the peritonæum* or abdominal viscera, which is of course exceedingly likely to follow these wounds and injuries, may readily be recognised. The patient lies on his back, with his knees drawn up; he breathes solely with the thorax, and not with the diaphragm or abdominal muscles; the countenance is anxious; the pulse small, wiry, and resisting, but becomes fuller after bleeding; there is severe throbbing pain, with great tenderness, more or less widely diffused; a dry tongue, constant nausea, or vomiting, or obstinate constipation, complete the catalogue. If the case proceed to a fatal termination, the belly swells from serous effusion (if this be the case the wound should be opened) or from tympanites; and the pulse becomes more frequent and weak, the patient retaining his senses to the last.

The *treatment* comprises opium or morphia, which may be given as enemas to allay pain and keep the wounded part at rest; fomentations; leeches if necessary; ice to allay sickness; and cold beef-tea by spoonfuls.

It is quite unnecessary to give purgatives in cases of inflammation of the bowels. It is true that the bowels will be obstinately costive; but this costiveness arises from their being inflamed, and unable to propel their contents onwards; and the proper remedies for it are such as will relieve the inflammation—that is, bleeding, leeches, fomentations, and calomel and opium. But if, in spite of common sense, the surgeon attempts to overcome the costiveness by colocynth pills and black draughts, he will soon induce obstinate vomiting, that will render all his other remedies nugatory. If in any case of inflammation of the bowels it is probable that they are loaded with fæces, the proper remedy is the repeated injection of warm water as an enema. To relieve the flatulent distension an enema of 1 *drachm* of the *essential oil of rue* well mixed with half a pint of gruel or soap and water, will be found exceedingly efficacious.*

* See Travers on Wounds of the Intestines, Lond. 1812; Hennen's Military Surgery; the observations on the treatment of Enteritis in Fergusson on Puer-

VI. ARTIFICIAL ANUS signifies a preternatural communication between the intestinal tube and skin. It may be a consequence of penetrating wounds, of abscess or ulceration of the intestines, or of mortification of intestine in strangulated hernia, and it is sometimes purposely made by the surgeon in case of imperforate anus, in order to afford an exit for the fæces. The external opening is irregular, everted, and red, and the surrounding skin excoriated. The aperture in the intestines adheres by its margin to the peritonæum, so that extravasation into the abdomen is prevented. That portion of intestine which is immediately above the aperture, and that portion which is immediately below it, meet at the artificial anus at a more or less acute angle, and present two orifices; one by which matters descend from the stomach, and another which leads down to the rectum. These two orifices are separated by a sort of crescent-shaped septum, formed by a projection of the mesenteric side of the bowel opposite to the aperture. Now it may readily be understood that the greater the aperture in the bowel, the more acute will be the angle at which the upper and lower portions meet, and the greater will the septum also be; and that, if the septum is large, it will act as a valve, and close up the orifice of the lower portion of bowel, causing any matters that come down the upper portion to escape externally, instead of passing into the lower.*

The consequences of this affection may be, 1st, that the patient may die of starvation, from the escape of the chyle, if the aperture is near the duodenum. 2ndly, that a portion of the intestine may protrude and form a hernia; besides the constant disgusting annoyance occasioned by the escape of fæcal matter and flatus.

Treatment.—If the affection is of recent origin, and especially if it is consequent upon strangulated hernia, the patient should remain in bed, and great care should be taken to keep the parts clean; and then, perhaps, the external aperture may contract and cicatrize. If the latter is very small, and if the passage between it and the bowel is of some length (a state of parts termed *fæcal fistula*), something may perhaps be done by compression, or by engrafting a piece of skin over the aperture; or by making an oval incision in the skin on each side of the aperture, and bringing the outer edges of the incision together by means of needles and the twisted suture; or by applying the actual cautery to the margin of the wound.

But if the loss of substance in the bowel is considerable, and the projecting septum large, the chance of recovery is not great. A pad of simple linen or lint may be worn to compress the aperture, and prevent discharge from it, or sometimes a hollow truss with a leathern or horn receptacle, may be used with advantage. Enemata are useful in all cases. Moreover, a tent may be thrust into both internal orifices, in

peral Fever; Griffin's Medical Problems; Holland's Notes and Reflections; Dr. Watson's Lectures; and Chisolm's Military Surgery.

* See the Chapter on Artificial Anus in Lawrence on Hernia, and Dupuytren in Dict. de Méd. tom. iii.

order to enlarge the lower one, and repress the septum, as proposed by Dessault. As a last resource, a small portion of the septum may be nipped and strangulated by the forceps, or enterotome invented by Dupuytren for that purpose.

VII. ABDOMINAL SECTION.—There is a class of cases of obstruction of the intestines, in which it is found, after death, that the mischief has been done by some one little band of lymph, the consequence of inflammation, and that if this could have been found and severed, the patient might have had at least a chance of recovery.

Intestinal obstruction may, however, arise from many other *causes* such as, 1st, *ileus*, or obstinate spasm; 2ndly, impaction of accumulated fæces, or, perhaps, of a large gall-stone, or intestinal concretion, as of chalk or magnesia, taken incautiously as medicines; 3rdly, solid growths within the intestine; 4thly, tumours pressing upon it from without; 5thly, stricture of the intestine; 6thly, invagination or intussusception, or the slipping of one portion into, and constriction by,

another. This condition is rarely recognized in time, and is often mistaken for dysentery, and the writer believes that many children die of it, without the true cause being known. The child is ill, probably vomits; is evidently in pain in the bowels, and usually passes the contents of the lower bowels mixed with more or less blood; afterwards blood alone. Most probably the parents send for medicine, and possibly get a powder containing some purgative, which makes the case worse or hopeless. The symptoms of strangulation continue; and if the patient survive long enough, there is a discharge of fetid bloody serum oozed out by the strangled bowel, and possibly a portion of bowel may be

* Invagination of the intestine, from nature, by Dr. Westmacott. A large coil of the small intestines, including the caput coli, has been engulphed within the ascending colon. The vermiform appendage is seen projecting out; and through an aperture, made artificially, the black and almost gangrenous intestine is seen strangled within.

passed down to, and protrude from the anus. In some desperate cases, the strangled part has bodily sloughed off, and been voided; the continuity of the canal has been established again, and the patient has recovered. The best remedy is opium. Lastly, constriction by bands of lymph; or by rents in the mesentery through which the bowel has slipped; besides internal hernia; obturator hernia, for example. Moreover, from whatever cause arising, the *symptoms* are usually much the same —viz., obstinate constipation; a vomiting first of a yellowish or greenish liquid, then of a feculent or stercoraceous matter; great "tympanitis," or distension of the intestines with flatus and fæcal matter, and occasional fits of colicky pain—arising from the efforts of the intestine to overcome the obstacle, during which the coils of the distended guts can be seen through the abdominal parietes. To these essential symptoms, tenderness, and other signs of inflammation are added in greater or less degree.

Now the practical question arises—suppose there were to be a case of evident mechanical obstruction of the bowels; that injections have been used as largely as they safely can; and that purgatives have been given till they do but add to the distressing vomiting; that leeches and opium and hip-baths have been resorted to for the relief of tenderness; and that some space has been given, if the symptoms are not very urgent, to see what nature unaided can do, and that the case remains unimproved—shall the patient be left to die? or shall surgical means be resorted to, to give him a chance? The author would say, let the patient settle his affairs, worldly and spiritual, and let an operation be resorted to.

The most favourable circumstances which such a case can present are, if the patient is not too much exhausted by a long continuance of pain and vomiting; if he can point to any one spot as the seat of uneasiness, and, probably, of stricture, and if an examination of the distended coils of intestine seems to confirm this suspicion; and if he has been known to suffer on former occasions from an attack of inflammation in the abdomen, thus making it probable that the obstruction is caused by bands of lymph, rather than by either of the other causes; and if the present attack have come on suddenly.

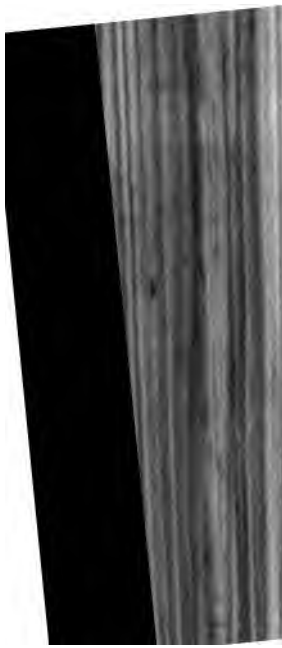
If the operation is determined on, the air of the apartment should be warmed; flannels dipped in warm water should be ready to protect the bowels if they protrude; chloroform should be administered, and the bladder emptied. Then an incision should be made through the linea alba below the umbilicus; the peritoneum be carefully opened, and the finger at once passed to the probable seat of obstruction. This seems to be most commonly found near the termination of the small intestines at the brim of the pelvis on the right side. To reach it, it is usually necessary to draw aside the distended bowels and to explore the mesentery. If a band is found, the finger must be passed under it, and a probe-pointed bistoury used to sever it, the wound should be closed with abundance of sutures, and a compress and bandage be placed over it. In one of the cases in which the

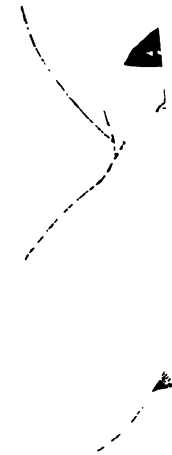
, the patient pointed beforehand with perfect accu-
ere the obstruction was found.
ator either fail in finding an obstruction, or in
sperate resource remains of opening the bowel, as
le, and stitching the opened part to the edge of the
tes so as to establish an artificial anus. Although
ave not hitherto met with much success, in all the
atients' sufferings have been much relieved thereby,
has resulted.*

AL ANUS FOR THE RELIEF OF OBSTRUCTION.—
n of the bowels is situated in the rectum or colon,
fæcal matter is entirely prevented, so that life is in
is the surgeon's duty to propose an operation for

referred to, comprise, 1, cases of *congenital* defi-
m in new-born children, in which an attempt has
essfully to open the bowel from the perinæum;
ble *stricture* of the rectum, or of some part of the
uction by cancerous and other growths within, or
or, in fact, by any other conceivable cause.
to such an operation, the surgeon must first ex-
oroughly by finger and bougie, inject water by the
every other method of establishing an accurate
course, to make an opening below the point of
useless. Then there are two places in which the
rformed:—
flexure of the colon may be opened by an incision
on. This operation was proposed by Littre in 1720.
the sigmoid flexure on the left, the cæcum on the
eemed expedient, be opened by an oblique incision,
perior spine of the ilium.
nay be opened in the *lumbar region* by a vertical
outer edge of the quadratus lumborum, just above
m, as was proposed by Callisen in 1817, or by the
proposed by Amussat in 1832. This is generally
ration. An incision through skin and fat may be
bove, and parallel to, the crest of the ilium, com-
pine, and carried outwards for from two to five or
g to the age and bulk of the patient. Taking the
e external oblique and latissimus dorsi muscles as a
eting the musculo-cutaneous lumbar nerves,—the

d comprehensive paper by B. Phillips, Med. Chir. Trans.,
copious bibliographical notices, and a *catena* of opinions;
R. Druitt, in the same vol.; and of others by Dr. Gold-
n in vol. xxx.; by Fergusson, Lancet, 1850, vol. i., p. 128,
paper on complications of hernia and obstruction of the
engravings and cases, by the late R. R. Robinson of Cam-
he author received much valuable information. Lond.





two ligatures must be pass
steady it when opened, and t
bowel to that in the skin whe
be done likewise when the sig
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nature of the disease which required the operation, and on the effects which this may have already caused. Out of forty-eight cases collected by Mr. Hawkins, there is scarcely one in which death can fairly be said to have been caused by the operation itself.*

IX. GASTROTOMY FOR THE RELIEF OF STARVATION.—In a case of cancer of the œsophagus, in which life was at the point of extinction by starvation from utter impossibility of swallowing; in which the trachea even had been opened for the relief of the breathing, and in which the rectum, as it always will in time, ejected the materials introduced as nutritious enemata, Dr. Habershon caused an aperture to be made into the stomach, through the left linea semilunaris, which was skilfully effected by Mr. Cooper Forster. Eggs, milk, and other articles of nourishment were introduced, and the man lived till the third day after the operation, with his sense of starvation relieved, and then expired in comparative comfort.†

X. In a case of acute inflammatory disease of the APPENDIX CÆCI, arising apparently from the impaction of a small mass of feculent matter, Mr. Hancock made an incision close above Poupart's ligament into the abdominal cavity, and gave issue to some offensive serum, to the great relief of the patient, who was moribund, but recovered. He proposes a similar operation for the purpose of letting acrid effusions drain away, in cases of unhealthy peritonitis, and the hint is a valuable one.‡

CHAPTER XVIII.

HERNIA.

SECTION 1.—NATURE AND CAUSES OF HERNIA GENERALLY.

Definition.—Hernia signifies a protrusion of any viscus from its natural cavity. But the word, used by itself, is restricted to signify protrusion of the abdominal viscera.

Causes.—The formation of hernia may be readily understood by considering that the abdominal viscera are subject to frequent and violent pressure from the diaphragm and other muscles by which they are surrounded, a pressure which tends to force them outwardly against the parietes of the abdomen. If any point of the parietes be not strong

* Almost all that is known of these operations is summed up in a paper by Mr. Cæsar Hawkins, Med. Chir. Trans., vol. xxxv., which contains copious references to the original memoirs of Amussat, Pring, Maitland, Teale of Leeds, Evans of Derby, Clement of Shrewsbury, Baker of Birmingham, and other English and Continental operators. Notes of a good case in which it was performed by Mr. Hutchinson, for obstruction by cancerous tumour following ovariotomy, Med. Times, 1859, vol. i., p. 11.

† Quoted in Ranking, vol. xxviii., from Guy's Hosp. Rep., vol. iv. 3rd Series.

‡ A short account of disease of the Appendix Cæci, cured by operation; by Henry Hancock. Lond. 1848.

enough to resist this pressure, some portion of the viscera may be forced through it, and form a hernial tumour externally.

The *predisposing* cause of hernia, therefore, is a weakness of the parietes of the abdomen, which may be produced by various circumstances. Thus, 1. Some parts of the parietes are naturally weaker than others, especially the inguinal and crural rings, and the umbilicus; and it is at these parts that hernia most frequently occurs. 2. The abdominal parietes may be weak from malformation, or congenital deficiency. 3. They may be weakened by injury or disease, such as abscesses, wounds, and bruises, or by distension by the pregnant uterus, or by obesity or dropsy. 4. In certain cases an unnatural elongation or laxity of the mesentery and other serous connections of the viscera and hypertrophy of the omentum by fatty deposit from a predisposing cause of hernia.

The *exciting* cause is compression of the viscera by the action of the muscles that surround them, and especially of the diaphragm. Hence hernia is so frequent a result of violent bodily exertion—lifting heavy weights and the like—especially if the patient have been previously weakened by illness. Moreover, it is not uncommon in persons afflicted with stone or stricture, from the immoderate straining that they employ in passing their urine.

The viscera most liable to hernial protrusion are the small intestines, omentum, and arch of the colon. But every one of them has occasionally been found protruded, partially or entirely—especially in cases of congenital deficiency of the abdominal parietes.

The SAC of a hernia is a portion of the *parietal* or *reflected* layer of peritoneum which the protruding viscera push before them in their escape, and which forms a pouch containing them. It very soon contracts adhesion to the surrounding cellular tissue, and consequently does not return into the abdomen when the viscera are replaced, although it must be observed, that a hernia may be pushed back *en masse*, sac and all, when great force is used in reducing a strangulated hernia. As the hernia increases in size, the sac also increases; partly by growth, partly by distension, and slight laceration or unravelling; partly by fresh protrusion of peritoneum. Sometimes it diminishes in thickness whilst increasing in capacity; sometimes, on the contrary, it becomes thick, indurated, and divisible into layers. Its *neck* (the narrow part which communicates with the abdomen) always becomes thickened, rigid, and more or less puckered, in consequence of the pressure of the muscular or ligamentous fibres which surround it. Sometimes the sac has two constricted portions, or *necks*—either because (as in oblique inguinal hernia) it passes through two tendinous apertures—(the external and internal abdominal rings)—or because the original neck has been pushed down by a fresh protrusion. Some herniæ, however, are destitute of a sac, or at least of a complete one. This may happen,—1. If the protruded viscus is not naturally covered by peritonæum; as the cæcum. 2. If the hernia occur in consequence of a penetrating wound. 3. In some cases of congenital umbilical

hernia. 4. Hernia may be considered virtually without a sac, if the sac has been burst by a blow, or if it has become entirely adherent to its contents. Instances, again, are known in which two peritoneal sacs have protruded through one and the same aperture in the abdominal parietes; and in which one sac has come down within a previously-existing one.

Division.—Hernia is divided into several species: 1st, according to its *situation*—as the inguinal, femoral, and so forth; 2ndly, according to the *condition of the protruded viscera*; which may be (*a*) *reducible* or returnable into the abdomen; (*b*) *irreducible*, that is, not returnable into the abdomen, but without constriction; or (*c*) *strangulated*, that is, subject to some constriction, which not only prevents their return into the abdomen, but also interferes with the passage of their contents, and with their circulation.

SECTION II.—REDUCIBLE HERNIA.

Symptoms.—A soft compressible swelling appears at some part of the abdominal parietes. It increases in size when the patient stands up; if grasped, it is found to dilate when he coughs or makes any exertion; and it diminishes or disappears when he lies down, or when properly-directed pressure is made upon it. If the sac contains intestine only (*entero-cele*), the tumour is smooth, rounded, and elastic; *borborygmi* (or flatulent croakings) are occasionally heard in it, and when pressed upon, the bowel returns into the abdomen with a sudden jerk and gurgling noise. If, however, it contains omentum only (*epiplo-cele*), the tumour is flattened, inelastic, flabby, and unequal to the touch, and when pressed, it returns without noise, and very slowly, the pressure requiring to be continued till it has nearly disappeared. But very often one hernial sac contains both intestine and omentum (*entero-epiplo-cele*);* and very frequently it is perfectly impossible to ascertain which it contains by any external examination.

Treatment.—This may be palliative or radical. The palliative plan is, to employ a *truss*, an instrument consisting of a pad placed on the seat of protrusion, and of a steel spring which passes round the body, and causes the pad to press with the requisite degree of force. In writing for a truss it is usual to give the circumference of the body at the hips, midway between the spine of the ilium and the trochanter. The patient must expect to find the truss rather irksome for the first week. It should be constantly worn by day; and if the patient will submit to wear it at night, also, so much the better. If he will not do this, he should, at all events, apply it in the morning, before he rises from the recumbent posture. The skin of the part which it presses upon should be regularly washed, and bathed with Eau de Cologne or spirit, else large boils are apt to form on it.

* From κήλη, *tumour*; ἔντερον, *intestinum*; and ἐπίπλοον, *omentum*. The word κήλη is frequently used in the older surgical terminology; ex. gr., *hydrocele*, a tumour containing water; *hæmatocele*, a tumour containing blood; *bubonocele*, a hernial tumour in the groin.

There are some cases in which the common truss fails to keep up a rupture comfortably, and for these the surgeon should be prepared to recommend other instruments, which are, for the most part, the property of various individuals, and each of which has some peculiarity adapting it to particular cases. *Coles's truss* has a spiral spring acting on the pad. The *MacMain lever truss* has a simple belt passing round the body, thus dispensing with the usual circular spring; and the pressure on the pad is effected by means of a strap passing under the thigh, and acting on a spring lever attached to the pad. *Salmon and Ody's* self-adjusting truss has a pad revolving on a ball and socket. The *Maidstone truss* allows the pad to slide on the spring, so that the circumference of the instrument may be adapted to the varying size or movements of the body. *Egg's truss* is said to be made of old sword-blades: it is very strong, though not irksome, and requires no fastening. *Adams's graduated pressure truss* has two springs of different curves, by sliding which on one another the amount of pressure may be varied. In *Tod's truss* the spring goes round the waist, and curves downwards to compress a pad at the internal abdominal ring. *Newson's* wire truss has a round wire, instead of a flat steel spring, which renders it less likely to be displaced. Trusses may have *French pads*, which are of an oblong-triangular shape, instead of oval, like the English; or pads filled with air; or with sand, which will retain any shape given to it; or may have springs going entirely round the body. Instead of a steel spring an elastic India-rubber belt may be used, such as are constructed by Bourjeard. Dr. Arnott has devised a truss, in which, by means of a wire, external to the steel spring, and capable of being tightened or slackened by a nut and screw, the amount of pressure can be regulated with the greatest possible nicety. Dr. Charles Edwards has invented one, in which the pad is capable both of revolving and of sliding on the spring. For children the *India-rubber* band and pad generally answer without a spring. A pad of hard polished wood is recommended by Mr. Dartnell. He also uses flannel instead of leather as a covering for the spring, as it can be washed.*

The trusses devised by Mr. Wood† have been employed with much success in curing small herniæ as well as in keeping up and preventing the increase of herniæ for which an operation for radical cure has not been deemed advisable. These trusses are of four kinds, viz., for *inguinal* rupture, *oblique* and *direct*; for *crural*, and for *umbilical* hernia. They are all based on a distinct principle, that of applying a flat and level pressure at the *sides* of the hernial opening instead of in the *axis*. Mr. Wood considers that the principle of a convex pad projecting into and exerting its chief pressure in the *centre* of the hernial aperture is erroneous, and calculated to increase the size of the hernia by invagination, the longer the truss is worn. The truss pad for *oblique* inguinal rupture is of the shape of an obliquely curved horse-

* It is made by Spratt, of Brook Street, Hanover Square. Dr. Charles Edwards's (of Cheltenham) is made by Weiss. Dartnell, Lancet, 1848, vol. ii.

† See Wood on Rupture Inguinal, Crural, and Umbilical, pp. 168, 224.

shoe, the outer limb (intended to press upon Poupart's ligament) being shorter than the inner, which is laid over the inner pillar of the ring. (See fig. 1.) The curve of the horseshoe is placed over the deep hernial opening, and the bearing of the side spring is exactly in the centre of the pad. When a radical cure is looked for the pad is composed of a hard smooth substance, boxwood being the most convenient. For peculiar cases a double C spring is made to work in the horns of the horseshoe under the side spring, or the hard surface may be covered by an India-rubber water bag of the shape of the pad. The pad for *direct* inguinal hernia is of the shape of an ovate ring with a hole in the middle opposite to the axis of the hernial opening. This exerts its chief pressure upon the margins, preventing their giving and enlarging under the pressure of the bowels. (See fig. 2.) The double bearing of the horseshoe and ring pads enable them, under sufficient pressure of the side spring, to keep in place better than the convex pads, while the tension of the integuments across the opening prevents the rupture from emerging there. The spermatic cord and pubic spine escape the injurious pressure of the pad by lying in the cleft or opening. For large and difficult cases of inguinal rupture, he employs a double or twin pad, each half of which presses upon each of the pillars of the ring or sides of the neck of the sac. The spring goes entirely round both hips, one end pressing upon the inner, and the other on the outer of the half pads, so that an increase of pressure can be made upon either half that may be desirable. The two pads are bound together by a transverse strap. Thus a lateral as well as a backward pressure is kept up. The pad for *crural* hernia is egg-shaped in outline, its bearing surface being flattened for pressure upon the front wall of the crural canal, its upper border rounded to support Poupart's ligament, and its lower tapered off to accommodate itself to the saphenous opening. (See Fig. 3, p. 556.) This is also sometimes provided with pad-springs.* (B shows a section.)

Fig. 1.

Fig. 2.

Radical cure.—If the patient is below the age of puberty, or not much above it, and if the hernia has not existed very long, a proper truss, if constantly worn, has in some cases effected a permanent cure. The herniary aperture, no longer subject to distension, then becomes con-

* These trusses are made by Mr. Matthews, of Portugal Street, Lincoln's-Inn Fields.

tracted and finally closed, and the neck of the sac obliterated. This cure may perhaps occur in two or three years; but, as a measure of precaution, the truss should be worn for two or three years more. This is most frequently the case with the umbilical and other herniæ of infants.

Fig. 3.

But the herniæ of older patients have commonly till of late in this country been considered as admitting of palliative treatment by truss only; and the patient has been doomed to wear the instrument for the rest of his days.

Modern surgery, however, has placed some means of radical cure at our disposal, which we shall describe more conveniently under the head of reducible inguinal hernia.

SECTION III.—IRREDUCIBLE HERNIA.

Definition.—Hernia is said to be *irreducible*, simply, when the protruded viscera cannot be returned into the abdomen; although there is no impediment to the passage of their contents, or to their circulation.

Causes.—Hernia may be rendered irreducible, 1, by an adhesion of the sac to its contents, or of the latter to each other, or by membranous bands formed across the sac. 2. By enlargement of the omentum or mesentery—whether from simple deposition of fat, or from sarcomatous or other organic change. 3. Omental hernia may be rendered irreducible by a contraction of that portion which lies in the neck of the sac, so that it is not stiff enough to stand against the pressure intended to push it back into the abdomen, but doubles up under it.

Consequences.—Irreducible hernia may produce sundry inconveniences. In the first place, the patient is often liable to dragging pains in the abdomen, or perhaps attacks of vomiting, which come on after food, or when he assumes the erect posture, because the protruded omentum or intestines being fixed, resist all distension or upward movement of the stomach. These inconveniences will be greatly aggravated, if the patient increase in corpulency, or become pregnant. Moreover, the protruded bowels being deprived of the support naturally afforded them by the abdominal muscles, their faeculent contents are apt to lodge in them, and frequently cause colic or constipation. Lastly, the bowel is greatly exposed to external injury, and in constant hazard of strangulation.

Treatment.—This may be either palliative or radical. 1. The *palliative* treatment consists in applying a hollow bag truss, or else a truss with a hollow pad, or circular India-rubber water pad, that shall

firmly embrace the hernia, and prevent any additional protrusion. The patient should avoid all violent exertion or excess in diet, and should never let his bowels be confined.

2. *Radical cure.*—It has occasionally happened, after confinement to bed for several weeks with fever or some other emaciating ailment, that a hernia, irreducible before, has been replaced with ease, owing to an absorption of the fat of the omentum or mesentery, and relaxation of the abdominal apertures. The same result has also in some cases been effected by art—by keeping the patient in the recumbent posture and on very low diet for six weeks or two months, and by the frequent use of glysters and laxatives, and at the same time by keeping up a constant equable pressure on the tumour by means of a bag truss made to lace over it. This plan is very uncertain as to its results, and will be effectually defeated if there are any adhesions; and, besides, there are not many patients who will submit to it. It will be more likely to succeed if the hernia is omental, than if it contains intestine. But several instances are known, in which, after the contents of old herniæ had been replaced, they produced so much irritation in the abdomen, that the patients were glad to compound for their life by keeping the hernia. Any surgical operation with the view of opening the sac, dividing adhesions, and returning the parts into the abdomen, is scarcely justifiable, as it would be exposing life to too great a hazard.*

SECTION IV.—STRANGULATED HERNIA.

Definition.—Hernia is said to be strangulated, when it is constricted in such a way, that the contents of the protruded bowel cannot be propelled onwards, and the return of its venous blood is impeded.

The *causes* of strangulation may be,—1. A sudden protrusion of bowel or omentum through a narrow aperture, in consequence of violent exertion;—a thing not unlikely to happen if a truss has been worn for some time, and then is carelessly left off. 2. Distension of the protruded intestines by flatus or fæces, or tumefaction and congestion of the omentum or mesentery. 3. Swelling of the neck of the sac may be a cause; and *spasm* was formerly considered so.

The *seat of stricture* is either the thickened portion of peritonæum which forms the neck of the sac, or tendinous bands external to it, at the internal or deep hernial aperture. Less frequently, it is lower down in the canal, and occasionally in large scrotal ruptures at the pillars of the superficial ring. In some cases the bowel has been constricted by membranous bands, or by fissures in the omentum within the sac itself, or by an old *neck* of the sac, see p. 552. But it must be recollected that the membranous aperture, through which the displaced bowel passes, does not exert any active force upon it;—on the contrary,

* See B. Cooper, quoted in Ranking, vol. xvi. A case in which Velpeau practised subcutaneous incisions for the relief of an irreducible hernia is related in Bull. Gen. de Thérap., 15th and 30th Aug. 1840.

it is the ruptured part which has been squeezed into a narrow aperture, and is pressing outwardly against that aperture. Yet the effect is the same in either case.

The *symptoms* of strangulated hernia are, *first*, those of obstruction of the bowels; *secondly*, those of inflammation. The patient first complains of flatulence, colicky pains, a sense of tightness across the belly, desire to go to stool, and inability to evacuate. It is true that stools may be passed if there be any fæcal matter in the bowel below the hernia, or if the hernia be entirely omental, but with very transient relief. To these symptoms succeed vomiting of the contents of the stomach, then of mucus and bile, and, lastly, of matters which have acquired a *stercoraceous* appearance, by being delayed in the small intestines. On examination the surgeon finds a rupture, which he cannot put back, and which is uneasy, tense, and incompressible. The communication between the abdomen and the misplaced bowel is almost, or, if the stricture be tight, is quite interrupted; and therefore the impulse felt on coughing is either diminished or altogether lost. Moreover, as Mr. Luke* very clearly pointed out, if the hernial tumour is examined with both hands, and if one hand is employed in grasping the body of the tumour, and two fingers of the other in feeling near the neck of the tumour for the impulse created by each act of compression, it will be found that the sensation of impulse will cease to be felt at the part where the stricture exists; and will not be felt all along the neck of the hernia, as it would if no stricture existed. If this state of things continue, the inflammatory stage comes on. The neck of the sac becomes tender, and tenderness diffuses itself over the tumour and over the abdomen, both of which become very painful and much more swelled. The countenance is anxious; the vomiting constant; the patient restless and despondent; and the pulse small, hard, and wiry. After a variable time, the constricted parts begin to mortify. The skin becomes cold, the pulse very rapid and tremulous, and the tumour dusky red and emphysematous; but the pain ceases, and the patient, having perhaps expressed himself altogether relieved, soon afterwards dies.

Varieties.—There is often considerable diversity in the rapidity and violence of these symptoms. If the patient be a strong adult, and the strangulation have commenced suddenly with a fresh protrusion during some forcible exertion, the inflammatory stage may come on instantly, and be followed by death in a very few hours. On the other hand, if the patient be old, if the hernia have been long irreducible, and have a large neck, and if the strangulation be produced by distension of the protruded bowel with flatus or fæces—the symptoms of mere obstruction may last many days before those of inflammation come on. To this latter class of cases the term *incarcerated* is applicable.† Again,

* Quoted in Mr. Ward's very able Memoir on Strangulated Hernia, Lond., 1854. See also Med. Times, Dec. 1854.

† There is great confusion in the use of these terms, as some surgeons employ the term *incarcerated* to signify what is generally known as *irreducible* hernia.

if the hernia be omental, the symptoms will probably be less acute than if it be intestinal; but not much less. *The bowels may act* in this case: also if a *portion* of the calibre of the bowel be constricted, and not the whole, so that a passage may be left: also if the vermiform appendix be the only part constricted;* but the surgeon must not think the case cleared up if the bowels act, if other symptoms remain.

Morbid Appearances.—After death from strangulated hernia, the bowels are found reddened, the upper portion of them much distended, and there are effusions of turbid serum and lymph. Around the sac the tissues are œdematous or emphysematous. The strangulated intestine is dark, claret-coloured, and turgid with blood, roughened in patches by a coating of lymph;—or displaying patches of gangrene, in the form of greenish or ash-coloured spots, which break down under the finger. The mucous and muscular coats, where they have been subjected to the pressure of the stricture, are liable to be ulcerated. The omentum is dark red; if gangrenous, it feels crispy and emphysematous, and the blood in its veins is coagulated. The sac also contains bloody serum.

Treatment.—The indications are, to return the intestine, or such portion of it as may be reducible; and for this purpose to divide any constricting part, if necessary.

The Taxis.—This is a Greek word, absurdly and pedantically used to signify the acts of gentle pressure with the hands, by which herniæ are reduced. The bladder having been emptied, the patient should lie down in an attitude of complete repose, and be put under the influence of chloroform; if this be not used, he may be made to lie in a warm bath, with his shoulders raised; and both his thighs should be raised towards the belly, and be placed close to each other, so that every muscle and ligament connected with the abdomen may be relaxed. If not narcotized, he should be engaged in conversation, to prevent him from straining with his respiratory muscles. In order effectually to remove the expulsive force of the diaphragm, Dr. Buchanan, of Glasgow, directs the patient to make a deep expiration, and to abstain from drawing in the breath as long as possible.† Then the surgeon, if the tumour be large, grasps it with the palms of both hands, gently compresses it, so as to squeeze out a little flatus and venous blood, and occasionally with his fingers gently moves the parts at the neck of the tumour, or perhaps tries to pull them very gently downwards, in order if possible to dislodge them.‡ This operation may be continued for a quarter or half an hour, or longer, if the tumour be indolent, but not

* Smyly on Hernia, Dublin Journal, May, 1863.

† Quoted from Glasgow Medical Journal, July, 1856, in Ranking, vol. xxiv.

‡ Mr. T. Hunt, late of Herne Bay, now of Alfred Place, in a communication with which he has favoured the author, condemns all kneading and pushing, and says that he believes that gentle, long-continued, and equable pressure will reduce every hernia, provided time and gentleness are allowed for the operation. Mr. Hunt's opinion is grounded upon numerous cases during a practice of thirty years.

so long if it be tender; and at last, perhaps, the surgeon will be delighted to hear a gurgling sound accompanying the return of a portion of intestine. The operator should recollect that too much force may bruise or rupture the viscera, or drive sac and all into the abdomen, or push them between the layers of abdominal muscles, and that he must not be satisfied with a partial reduction of the volume and tension of the tumour, if the vomiting remains unrelieved; because, as Mr. Mayo has shown, such a diminution might be caused by merely forcing the serum contained in the sac into the abdominal cavity.

Taxis with Inversion.—In many cases of strangulated hernia resisting the ordinary application of the taxis, reduction has been effected by raising the pelvis and depressing the shoulders, so as to turn the trunk of the patient "topsy turvey." This is best done by raising the pelvis on a chair placed under the lower part of the mattress of the bed, and letting the patient's head and shoulders rest upon the bed itself. Care must be taken to keep the legs bent up to the body, and the trunk itself bent forwards, so as to relax completely the aponeurotic structures in the groin. Inversion of the patient acts by the gravitation of the viscera towards the diaphragm, and the dragging of the mesentery and omentum out of the neck of the sac. This, aided by a gentle application of the taxis, and by frictions over the belly made in a direction *from* the strangulated part, will often succeed in overcoming the strangulation, when other means fail. If the taxis do not succeed, certain auxiliary measures are commonly resorted to.

(*a*) The first to be mentioned is *chloroform*, inhaled till it produces complete relaxation and unconsciousness.

(*b*) *Bleeding* to the approach of syncope may be tried if the patient is robust, the hernia small and of recent date, and if there is much tenderness of the sac or of the abdomen, in which latter case it may be employed before trying the taxis.

(*c*) The *hot bath* (96°—100° F.) continued long enough to produce great relaxation, is useful in similar cases; but it must be recollected that a delicate person will not be very likely to bear the shock of an operation, if bled or boiled to death's door first of all.

(*d*) A large dose of *opium*, or *morphia*, is a remedy most useful in cases of acute strangulation, if for any reason chloroform be not given; and especially if the pain and vomiting are violent.

(*e*) The *tobacco enema* (℥j. and Oj. aq. ferv. allowed to stand ten minutes, and half to be used at a time) has certainly been successful in many cases, especially of inguinal hernia; but it is a most dangerous remedy. It has proved immediately fatal to some patients, and has rendered others incapable of surviving the shock of the operation.

(*f*) *Cold* applied to the tumour by means of pounded ice or a freezing mixture (F. 114) in a bladder, is a remedy commonly enumerated; and is said to be most applicable to large scrotal hernia when the symptoms are not very urgent. But it is not without its hazards; for it may cause gangrene of the skin if applied too long, or if hot

applications are incautiously used after it; and, above all, it may be the excuse for injurious delay. Certainly it should not be used if painful.

(g) *Purgatives and enemata* are irritating and mischievous in sudden acute strangulation, but vastly beneficial if the patient is aged, the hernia large and long irreducible, and if the attack has been preceded and caused by constipation. Large doses of calomel and colocynth are the best purgatives, and the enemata should consist of as much gruel or water as can be injected without causing very much pain or distension. Moreover, Dr. O'Beirne* has fully shown that greater benefit is to be derived in cases of incarcerated hernia and obstinate constipation from passing up a long tube (the tube of a stomach-pump answers very well) into the colon, than from the use of the ordinary short enema-pipe. The long tube relieves the bowels of their flatus; and of course by diminishing the bulk of the contents of the abdomen, renders the return of the hernia more easy.†

Operation not to be delayed.—In old standing cases, occurring to aged people with large herniæ, the surgeon may be justified in waiting some time to try the effect of his remedies; but in acute cases occurring to young people, we would earnestly inculcate the rule that if the taxis, aided by chloroform or opium, do not very speedily succeed, it is the safest plan to perform an operation for dividing the stricture without further delay. It is very well remarked by James of Exeter,‡ that *time* is of the most extreme value in the treatment of strangulated hernia. The earlier the taxis is tried, the more likely it is to succeed; before the bowel has been long and strongly nipped, and thickened by congestion. The same may be said of an operation.

The *operation* that may be performed may be either the old one of opening the sac, dividing the stricture, and returning the intestine; or *secondly*, the plan of division of the stricture, without opening the sac; or *thirdly*, Mr. Gay's operation for limiting the incisions to parts investing the neck of the sac. The manner of operating for each variety of hernia will be found in the following sections. Here we make a few observations applicable to the subject generally.

1. *Supposing the sac to be opened*, the intestine should be well examined, and especially that part of it which has been actually compressed by the stricture, and which should be gently drawn down for that purpose. If it be merely dark claret-coloured from congestion, or slightly roughened with lymph, or if it exhibit a few black patches of ecchymosis, it should be returned—the operator being careful to replace it bit by bit—intestine before omentum—and those parts first which protruded last. The wound may then be closed with sutures, and a firm compress be placed upon it.

2. If the hernia were irreducible long before it was strangulated,

* James O'Beirne, M.D., New Views of Defecation. Dublin, 1833.

† Vide Lancet, July 6 and 27, 1839; also James's Retrospective Address, in Prov. Med. Trans., 1840; and O'Beirne on Defecation.

‡ On the Operations for Strangulated Hernia. Lond., 1859.

and if its contents were united to the sac by firm and broad adhesions, they should not be disturbed. But if the adhesions are recent, or very thin and slight, they may be cautiously torn or divided, and the bowel be returned.

3. If the intestine is mortified, which will be known by the softened green or ashy spots, the mortified parts should be slit open, and attached by sutures to the skin on each side, the stricture divided, and the patient left to recover with an artificial anus. Again, if a large portion of intestine, which has been long irreducible in an elderly person, appear extremely dark and advanced towards sphacelus, so as to render it doubtful whether it would be capable of performing its functions when returned, it has been advised to make an opening into it, and so afford an outlet for its contents through an artificial anus; but such a proceeding must not be rashly resorted to.

4. If the omentum is gangrenous, or if it is thickened and indurated, it would, if returned, excite dangerous irritation of the peritonæum. In this case some surgeons advise it to be left to granulate in the sac, or to cut it off close to the neck of the sac, and leave it there as a plug to prevent further protrusion. Macfarlane and others, on the contrary, recommend it to be cut cleanly off, and all the vessels to be tied with fine silk ligatures, and the end to be then passed quite into the abdomen, breaking up any adhesions about the neck of the sac, if necessary; thus avoiding the dragging pains and colic which are liable to occur if a portion of the omentum or intestine is fixed. It is better, however, to tear slowly with forceps through the healthy part of the omentum, so that the numerous small vessels may be so stretched and twisted by the process that few, if any, ligatures may be required.

5. But it may happen that there may be a portion of intestine concealed within the omentum, and completely enveloped in a kind of sac formed by it. This is especially liable to be the case in the umbilical hernia. Therefore, to use the words of Mr. Prescott Hewett, "when the hernial sac appears to contain thickened omentum only, the omentum ought to be drawn out and carefully examined, to see that it does not form a sac containing a portion of intestine."* If it is thickened and firmly united to the neck of the hernial sac, throughout its whole circumference, an incision should be carefully made through it; bearing in mind that it is often extremely thick, and that the intestine may be firmly adherent to its inner surface. In fact, as Mr. Hewett says, the surgeon ought *carefully* to "examine every portion of omentum which is in a hernial sac, so as to ascertain that no knuckle of intestine is contained within its folds, before it is returned into the abdomen, left in the sac, or removed altogether."

Division of the Stricture external to the Sac.—Petit, Aston Key, Luke, and other eminent surgeons have recommended that the stricture should be released without opening the sac itself. The argument in favour of this proceeding is, that less injury is inflicted; that there is no rough handling and exposure of the intestine; and that the case is

* Med. Chir. Trans., vol. xxvii.

brought nearer, as regards safety, on a level with one in which no operation has been performed. The argument is confirmed by experience; and this mode of operating should always be adopted, unless there is some reason to the contrary. It is especially advisable, when the hernia is of very great size, and has been long irreducible, so that the idea of returning its contents could not be entertained; and when the hernia is small and of quite recent date. In a similar case, M. Guérin has divided the stricture by means of a subcutaneous incision.*

Mr. Gay's modification of this operation consists in making a small incision, near the neck of the sac, and carrying the tip of the forefinger to feel for the seat of stricture, and dividing it by a *bistouri caché*. We shall allude to this operation again when speaking of femoral hernia, to which it is chiefly applicable; and may remark that the advantages claimed for it are, that it meddles only with healthy parts, is slight, comparatively safe, and easily performed, and that there is no long convalescence.

Seutin's Plan.—Baron Seutin has described a method of dilating the stricture, which he has employed so successfully that he rarely has had occasion to use the knife for strangulated hernia. It consists in insinuating the tip of the forefinger into the constricting orifice, pushing the skin before it, and dilating it forcibly. There is a germ of reason in this which makes it well worthy of trial. It is open, however, to the serious objection that the already injured and strangulated viscera are exposed to further damage by the forcible traction and pressure of the finger.†

Hernia reduced en masse.—When the taxis is used forcibly for the reduction of a strangulated hernia, the tumour, sac and all, may be forced back through the herniary aperture, and lie between the abdominal muscles and the peritonæum; or between the muscles and the fascia transversalis. Or, according to Mr. Birkett, the neck of the sac may be burst, "so that the intestine escapes into the loose connective tissue between the peritonæum and internal abdominal fascia." In such a case, the symptoms of strangulation continue, and although the tumour disappears outwardly, yet there will be symptoms of fulness and tenderness above Poupart's ligament, in the situation of the internal ring. The first thing to be done is to make the patient stand up and cough, in order if possible to bring the hernia down again, when it should be operated on without delay; but if this does not succeed, a

* Vide Fergusson's Practical Surgery, p. 526. Guérin, Gaz. Méd. de Paris, 7th Aug. 1841; Mr. Key's Memoir, on dividing the stricture external to the sac; Luke, Med. Chir. Trans., vol. xxxi.

† The surgeon seeks with his forefinger for the aperture that has given issue to the hernia, pushing up the skin sufficiently from below: then with the pulp of the finger towards the bowel or omentum, he insinuates it between the viscus and the aperture. This proceeding demands perseverance. When introduced, the finger is to be hooked, and made to stretch the ring till a sensible dilatation or tearing is produced. The plan appears to have been most successful in femoral hernia; and when stricture was seated at the external abdominal ring. Quoted in Ranking, vol. xxiv., p. 164.

cautious incision should be made through the abdominal parietes, over the suspected seat of the disease; the tendon of the external oblique should be divided, so as to lay open the internal abdominal ring; and the sac if found should be drawn down, the stricture divided, and the case be then treated according to the ordinary rules.*

After-treatment.—After the hernia has been returned, a compress—a towel, for instance,—should be put on the site of the tumour, and be retained with a bandage, so as to prevent any protrusion from coughing, sneezing, or any other accidental exertion, and the patient should have a full opiate. The surgeon should not be in haste to get the bowels to act, and should abstain from giving salts and other purgatives; for as the intestine that was constricted remains for some time inflamed, weakened, and incapable of propelling its contents, they would but irritate it uselessly. Castor-oil and laudanum may be resorted to after twelve or twenty-four hours. Tenderness, pain, and other inflammatory symptoms may be allayed by leeching, fomentations, and opium. Free exit should be afforded to pus. A truss should be applied before the patient gets up again. Mr. Wood suggests that in cases in which this operation is done, and there appears to be little or no active inflammation or disorganization of the parts, a silver-wire suture may be put into the sides of the hernial opening, so as to effect a radical cure of the hernia. Such a proceeding will scarcely increase the risks of inflammation, since this, when dangerous, affects the bowel itself which has been strangulated, and is of little importance in the parietes of the sac.

SECTION V.—REMARKS UPON THE DIAGNOSIS AND COMPLICATIONS OF HERNIA.

We may remark that hernia is a malady extremely common in every rank of life, and one for which the practitioner should never fail to make inquiry, in cases of disturbance of the abdominal viscera.

1. *The patient may not be aware that he has a hernia*, or if aware of it, may think it of no consequence, or may be deterred by *mauvaise honte* from mentioning it. For example, an elderly clergyman of eminence consulted the writer a few years since, respecting various dyspeptic symptoms; nausea, loss of appetite, and painful sensation of dragging at the stomach, and irregularity of the bowels. When asked if he was ruptured, he said, that he had never thought it worth mentioning, but that whilst preaching, some time ago, he had felt something come down into the scrotum. He had in reality a large double scrotal rupture, which was the cause of his dyspepsia.

But it is more particularly when a patient is affected with vomiting and constipation, especially if the face is pinched and anxious, that the surgeon should inquire for, or rather should examine for himself, the *ordinary* seats of hernia, such as the inguinal and femoral rings and the

* Luke, Med. Chir. Trans., and Med. Gaz., 5th May, 1843; Report of discussion on a paper by Mr. Birkett, at Med. Chir. Soc., Med. Times, June 26, 1852.

umbilicus, and the *extraordinary*, such as the linea alba, and the thyroid and ischiatic foramina. It would be a terrible thing to be treating a patient for enteritis, and let him die of strangulated intestine.

2. *The patient may have a tumour*, at one of the common seats of hernia, *which is yet no hernia*. The commonest example of this is an enlarged gland at the bend of the thigh. Yet if, with such a tumour, a patient should have symptoms of strangulation, the surgeon should not hesitate to cut down upon it. There often has been found a small hernia behind such a tumour; and in any such case the rule is, *if in doubt, operate*.

3. *The patient may have a hernia*, reducible, or irreducible, which yet is *not the cause of the symptoms*. There are numberless causes of internal strangulation, which may exist along with a hernia. *First*, the bowel may be strangulated within itself; a condition known as intussusception, and described at page 547. *Secondly*, it may be strangulated by an awkward twist on its own axis. *Thirdly*, it may be tied down by some accidental band, the result of previous inflammation; a thing that should always be inquired for. In women, bands of adhesion not seldom exist between one ovary and some adjoining part: and this should be borne in mind. *Fourthly*, the bowels may be simply matted together by recent adhesions, the result of subacute inflammation. *Fifthly*, they may be thrust through an aperture in the diaphragm. (See *Diaphragmatic hernia*.) So that in any case, if the condition of a hernia does not account for the symptoms of strangulation, the possibility of some other cause should be looked for. The following cases may be examples. The author was sent for to see a stout elderly man, whom he found in bed, with vomiting, and intense pain of eight hours' duration. On inquiry, it was discovered that he had an umbilical hernia; but this was reduced and not tender, although there was great tenderness and fulness in the vicinity. The bowels had been open the day before. Two grains of opium were administered. At the next visit, the writer was shown a large quantity of bloody serous fluid which had passed from the bowels. Another dose of opium was given, and the patient kept under its influence. Late at night some bilious matter passed, and the patient gradually recovered. These were symptoms of intussusception.

Whilst the author was correcting these pages in 1857, he was sent for to see a patient æt. 57, ill for a week, with pain in the bowels and vomiting. The man's countenance exhibited severe suffering; he was constantly vomiting a white frothy liquid, and said he had burning pain in his stomach. Had had double-scrotal rupture from infancy. On examination both ruptures were thoroughly reduced; and the forefinger, pushing the flabby scrotum before it, could be passed up through tendinous apertures an inch in diameter, into the abdomen. Everything was soft in the neighbourhood. But in the left iliac fossa was a large swelling, somewhat nodulated. There was great tenderness in the right hypochondrium. Repeated enemata brought away enormous quantities of small *pale brown* lumps, and the swelling in the sigmoid

flexure disappeared; but it took two days to bring down *dark green* bile from above.

If a patient with *irreducible* hernia be attacked by colic, or enteritis, or peritonitis, the case will present many of the features of strangulation. Yet it may perhaps be distinguished by noticing that the pain and tenderness did not begin at the neck of the sac, and are not more intense there than elsewhere. The diagnosis will be very obscure if the inflammation commences on the omentum or intestine in the sac. But the general rule is, *when in doubt, operate.*

4. "Strangulation may occur in a person the subject of *double hernia*, and a doubt may arise as to which is the hernia requiring operation. In such a case, the hernia that has existed the longest, and is the most tense, should be the one first subjected to the knife."*

5. *Reduction en masse.*—Lastly, the possibility of this accident should be remembered. (See page 563.)

SECTION VI.—INGUINAL HERNIA.

Definition.—Inguinal hernia is that which protrudes through one or both abdominal rings.

Varieties.—There are four varieties. The oblique, direct, congenital, and encysted.

1. The *oblique* inguinal hernia is the most common. It takes precisely the same route as the testicle takes in its passage from the abdomen into the scrotum. It commences as a fulness or swelling at the situation of the internal abdominal ring, that is to say, a little above the centre of Poupart's ligament, next passes into the inguinal canal (and in this stage is called *bubonocele*), and if the protrusion increase, it projects through the external ring, and descends into the scrotum of the male, or labium of the female. The *coverings* of this hernia are, 1, Skin. 2, A thick layer of cellular tissue derived from the *superficial fascia* of the abdomen, in which the superficial *epigastric artery* ramifies. 3, The *fascia spermatica externa*, a tendinous layer, derived from the intercolumnar bands, a set of curved and transverse fibres, which connect the two margins of the external ring. Under this lies, 4, the *cremaster muscle*, sometimes called *tunica communis*. 5. Next comes the *fascia propria vel infundibuliformis*, a cellular layer continuous with the *fascia transversalis* of the abdomen; and lastly, 6, the sac. The *deep epigastric artery* is always internal to the neck of the sac. The *spermatic cord* is generally behind the sac; but, in some large and *direct* cases, the parts which compose the spermatic cord are separated by the tumour, so that the vas deferens and spermatic artery lie sometimes in front, sometimes on either side of it. (See figs. 4 and 8, right side.)

2. The *direct* inguinal hernia usually protrudes before it the *conjoined tendon* of the internal oblique and transversalis muscles, just

* R. R. Robinson, on Complication of Hernia, Lond. Jour. Med., 1851.

behind the external ring. Its coverings are the same as those of the oblique variety, except the fascia propria and cremasteric fascia, for it has no connection with the cord. The epigastric artery runs external

Fig. 4.*

to the neck of the sac. This hernia may, however, separate or burst through the conjoined tendons before it. In a few rare cases it has been found to protrude *outside* the border of the conjoined tendon and to be covered by a few cremasteric fibres. The spermatic cord generally lies on its outer side. (Figs. 5 and 8, left side.)

3. The *congenital* hernia is a variety of the oblique, and is so called because the state of parts which permits of it exists only at or soon after birth. A portion of omentum or intestine accompanies the testicle in its descent, and passes down with it into the very pouch of peritonæum which forms the *tunica vaginalis reflexa*, before its communication with the general peritonæal cavity has become obliterated. The sac of this hernia is consequently formed by the tunica vaginalis; its coverings in other respects are the same as those of the oblique variety, and the protruded bowel lies in immediate contact with the testicle, and if not replaced generally adheres to it. (Fig. 6.)

4. The *encysted* (or *hernia infantilis*) is a sub-variety of the congenital. The protruding bowel pushes before it a sac of peritonæum either into or close behind the tunica vaginalis, and this tunic and the sac adhere very closely together. This hernia, therefore, has, as it

* Figure 4, quoted from Med. Times, 1864, vol. I., p. 220, shows the parts of inguinal rupture seen from the front; *b*, shows the fibres of the internal oblique normally covering the deep ring and restraining protrusion.

were, two sacs: viz. one proper sac, and another anterior, composed of the tunica vaginalis, which in these cases is very liable to be the seat

Fig. 5.*

of hydrocele. Fig. 7 shows another variety of the encysted hernia, in which the sac is apparently formed of tunica vaginalis, but its communication with the testicle is closed.

Diagnosis.—1. The difference between the *oblique and direct inguinal herniæ*, and their relations to the epigastric artery, and to the crural ring and Poupart's ligament, are shown in Fig. 8. In the oblique, the neck of the tumour inclines upwards and outwards, and causes a fulness extending up to the middle of Poupart's ligament. In the direct it inclines (if at all) rather inwards; and when the hernia is reduced, the finger, carrying integument before it, can be passed straight back into the abdominal cavity, feeling the edge of the rectus muscle internally, and the os pubis close below. But in old cases of oblique hernia, the neck of the sac is dragged down towards the middle line, so that all distinction is lost.

2. *Hydrocele* may be distinguished from hernia by its beginning at the bottom of the scrotum; by its being semi-transparent and fluc-

* This diagram, fig. 5, gives an *internal* view of the parts concerned in the formation of inguinal, crural, umbilical, and obturator hernia; *a*, the superficial ring seen through the opening at which *direct* hernia protudes; *b*, the deep ring through which oblique hernia passes; *c*, the crural ring; *f*, the epigastric artery; *d*, the umbilical ring; *e*, the obturator opening.

tuating, and preventing the testicle from being clearly felt (whilst the cord can be distinctly felt above it); and by not dilating on coughing.

Fig. 6.*

Fig. 7.

Whereas hernia begins at the top of the scrotum; it is not transparent; does not fluctuate; does not prevent the testicle from being clearly felt, although it obscures the cord; and dilates on coughing. But hernia may and does often coexist with hydrocele, the former beginning from above, the latter from below. Moreover, a hernia, consisting of intestine greatly distended with flatus, or a sac containing effused fluid, has been known to be as transparent as a hydrocele.

3. *Hydrocele of the Cord*, if low down, may be distinguished by its transparency and fluctuation; but if high up, it may extend into the

* From the King's College Museum. Fig. 6 exhibits a congenital omental hernia of the right side. Fig. 7, an encysted hernia; a kind which was first described by Hey, of Leeds, in a letter to Gooch. (Vide Gooch's Chir. Works, vol. ii., p. 217.) He says: "The intestine in this case had forced its way into the scrotum before the tunica vaginalis had formed its adhesion to the cord, but after its abdominal orifice was closed: under which circumstance it brought the peritonæum down with it, forming the hernial sac: contrary to what happens in the hernia congenita, where the intestine descends before the orifice in the tunica vaginalis has closed, and consequently has no hernial sac but that tunic."

abdominal ring, and receive an impulse on coughing, and the diagnosis be very difficult. But as a hernia may be concealed behind this kind

Fig. 8.

of tumour, the rule, *when in doubt, operate*, should be acted upon in case of symptoms of strangulation.

4. *Varicocele* (or *cirsocele*), which signifies a varicose enlargement of the spermatic veins, resembles hernia, inasmuch as it increases in the erect posture, and perhaps dilates on coughing; but it may be distinguished from hernia by its feeling like a bundle of distended veins or a bag of worms; and although, like hernia, it disappears when the patient lies down, and the scrotum is raised, still it quickly appears again, if pressure be made upon the external ring, though that pressure would effectually prevent a hernia from coming down again.

5. Lastly, a testicle that has not come down through the external abdominal ring into the scrotum, has been frequently confounded with a *bubonocele*, or small hernia in the inguinal canal; and has been compressed with a truss, to the great pain and detriment of the patient. A little care and attention will prevent this mistake.

Treatment.—Inguinal hernia, if *reducible*, must be kept up with a truss. Care must be taken not to let the pad bear against the spinous process of the pubes, or the spermatic cord. (See page 556.)

Radical Cure.—From the earliest times attempts have been made to

produce a radical cure of this kind of hernia, especially by measures calculated to obliterate the sac. Thus excision of the sac, and of the testicle with it;—ligature of the sac;—pressure by hard trusses; injection of iodine; the use of caustics, so as to produce a slough and subsequent firm cicatrix; the introduction of isinglass, blood, and goldbeaters' skin, have been practised with much danger and little success. At present there are operations, of established repute, which act by plugging up and closing the herniary apertures.

Gerdy's Operation.—More than twenty years since, M. Gerdy proposed a method of pushing a fold of integument up as far as possible into the neck of the sac, securing it in this inverted or invaginated position by means of two sutures (both ends of a ligature being passed from within the invaginated skin), and then denuding the pouch of invaginated skin of its cuticle by means of liquor ammoniæ, so that the surfaces of skin and peritonæum thus opposed to each other respectively may adhere, and the neck of the sac be effectually plugged. This operation was practised by Mr. Bransby Cooper with some benefit. For the herniary aperture in Mr. Cooper's patient was so large before the operation that the bowel could not be kept up by a truss; whereas, after the operation, a common truss enabled the patient to pursue a laborious occupation with safety and comfort.*

Wutzer's Operation.—Professor Wützer of Bonn has performed this operation since 1838, and it was introduced into England by Mr. Spencer Wells in 1854. The essential parts of it consist in the invagination of a portion of the coverings of the hernia—including skin of the scrotum, fascia, and sac—which are introduced into the inguinal canal; in the use of a wooden plug which shall retain the invaginated tissues there, and which shall be of such a size as to fill the canal as nearly as possible; and in the use of an outward wooden pad, of corresponding size and shape to the plug, which shall be so applied, that by means of equable pressure the opposed surfaces of the invaginated portion of sac shall adhere, so that the neck of the sac shall be plugged up, and obliterated.

The original instrument of Wützer consisted of a roundish plug, with cover to match. The subjoined drawing represents an instrument enlarged and improved by Professor Rothmund of Munich, and subsequently by Mr. Spencer Wells. Mr. Redfern Davies has since suggested that the plug should be made to expand like a glove-stretcher, so that it may fill out the internal ring. The structure and application of it will be readily learned from the following description of the operation.†

The patient's bowels should have been well cleansed by castor-oil a day or two previously, and the rectum be emptied by enema on the morning of the operation. The bladder should be empty, the hair of the

* Bransby Cooper, Guy's Hosp. Rep., Oct. 1840.

† See Spencer Wells, first paper, Med. Chir. Trans., vol. xxvii., 1854; also his Lecture in Med. Times, 1858, vol. i., p. 79; and paper in the Dublin Quar. Journ., Med. Sc., May, 1858. Redfern Davies, Med. Times, 6th August, 1859.

affected side removed, and the hernia carefully reduced. The patient should be in the same position as for the taxis. The surgeon stands on the side on which he operates.

Fig. 9.

The first step consists in invaginating the sac and its coverings. The surgeon using the left forefinger for the left side "places it," says Mr. Wells, "on the scrotum, about an inch below the external ring, and then pushes a fold of the scrotum before his finger, with a little rotatory movement slowly and steadily into the canal, keeping the palmar surface of the finger turned forwards and a little outwards, until it is well under the tendon of the external oblique, and the plug of scrotum is well pressed up to, or through, the internal ring." He must make sure that his finger is within the inguinal canal, beneath the tendon of the external oblique, and that it has not merely slipped up under the skin, outside the tendon.

The next step is, to introduce the wooden plug; which should have the needle or needles passed within it, so far as may be, without permitting their points to project. The surgeon taking it in his disengaged hand, is directed by Mr. Wells to bend the finger which is in the canal, and slip the plug along its dorsal surface, so as to introduce the plug adroitly, whilst withdrawing the finger. Here, again, the operator must be on his guard, both that the invaginated sac and skin do not come down with the finger, and likewise that the wooden plug be introduced into the inguinal canal, and not merely slipped up under the integument; and following Mr. Wells's authority, must feel that the external oblique tendon lies over, and rolls over it; which fact ought also to be ascertained with regard to the preliminary introduction of the finger.

The next point is, to push the needle or needles onwards, till their points come through the skin. Then the cover must be adjusted, and fixed by the screws—the needles also be fixed in their places by screws; their steel points removed and knobs put on, and the handle of the instrument be taken off.

Thus it will be evident that two surfaces of sac are pressed together, whilst the inguinal canal is filled with invaginated tissue; and now the object is to get the opposed surfaces of sac to adhere. The means

thereto is the pressure which may be produced by the screw. The part should be examined every day, by raising the cover, and the pressure equalised, if need be, by a little cotton wool. The patient must be kept in bed, with his knees and scrotum supported. About the fourth or fifth day, inflammatory redness and swelling are seen around the needle punctures; in another day or two, suppuration follows, and serous fluid begins to ooze from the invaginated skin. Now the instrument may be removed, and it will probably be found, by pulling at the skin of the scrotum, that adhesion has taken place firmly; if not, the instrument may be replaced for two or three days longer. If the pressure is too severe, or unequal, or continued, of course sloughing may occur.

"About six or seven days may be allowed," says Mr. Wells, "from the period the instrument is applied, and from seven to fourteen more, till cicatrization is complete; so that the patient must be prepared for a three weeks' confinement to his room. After this, a light truss with a weak spring, and large, well-stuffed pad must be worn for about three months, during which time the patient must abstain from violent exercise."

This operation has now been performed in a large number of cases in England, but has not been followed by such a proportion of permanently successful cases as to enable the surgeon to reckon with any degree of confidence upon its results, although in some cases, when it has failed of complete success, it has enabled a truss, heretofore useless, to be worn with benefit. Mr. Wood has shown that the hinder part of the canal remains unobliterated, and that the rupture generally returns by slipping behind the invaginated tissues, and then unfolding the invagination. (Wood on Rupture, p. 84.)

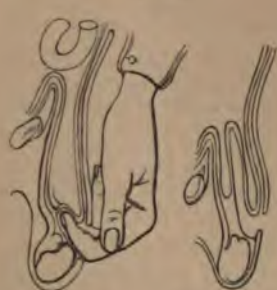
Treatment by metallic stitch.—Mr. Spencer Wells, in August 1858, in a case in which Wütz̈er's operation had been performed, and had been followed by some bulging, and a threatening of a return of the hernia, pushed a fold of scrotum up to the external abdominal ring, and passed a handled needle along his finger, and for an inch behind the external oblique tendon. The needle was made to penetrate the skin, and draw back an iron wire, each end of which was secured by a skein of cotton. After seven days the wire was withdrawn, and it was found that some amount of thickening had been produced: the truss was applied again, and a perfect cure followed.

To Mr. Redfern Davies, of Birmingham, is due the credit of applying a simple form of operation to the femoral and ventral hernia. For instance, in a case of femoral hernia, after it has been returned, the finger or fingers are made to carry a plug of invaginated skin and sac as far as possible into the femoral ring. Then a curved tube, containing a needle, is carried on the finger well through the ring; the needle is made to pierce the double integuments, and to bring through a silver wire suture; one, two, or more such sutures are passed, according to the size of the rupture; the ends are passed through small pieces of vulcanized India-rubber, and are secured by split shot clamped upon

them after they have been drawn tight. In about eight days the wires are removed; in eight days more the patient may get up and wear a light truss, till the invaginated plug is firmly secured. The application of this method to ventral hernia will be evident.*

Wood's Operation.—In the last place, we come to the operation devised by Mr. John Wood, of King's College Hospital, which the author has seen him execute with the most consummate skill, and the good effects of which he has witnessed in a case in which Wützer's operation had failed. Mr. Wood's operation is based upon a principle diametrically opposite to that of Wütz er, of which he conceives that the principle of dilating the hernial apertures by means of a plug, is erroneous and injurious, not effecting the object proposed, and being moreover calculated to increase the size of the rupture in case of failure to produce a cure. The steps of his own operation are intended to draw forward the hinder and inner walls of the hernial canal by transfixing the conjoined tendon and to unite it to the front and outer wall by suture, so as to close up the hernial canal entirely. He invaginates the hernial sac without including the skin, and by the arrangement of the sutures draws up its fundus into the deep hernial opening. (See Fig. 10.) On each side, the pillars of the superficial ring are bound closely together, no skin being suffered to intervene. The conjoined tendon and Poupart's ligament are caused to adhere across the cord, and are blended in one mass of adhesion with the invaginated sac and pillars of the superficial ring.

Fig. 10.



The instruments now used by this surgeon in this operation are very simple, consisting of a small tenotomy knife, and a stout, semicircular needle mounted in a strong handle with a point flattened anteroposteriorly, and adapted rather for splitting the tissues than for cutting through them. The needle is introduced each time unarmed. When the tissues are transfixed, a piece of stout copper wire, silvered, about 2 feet long, is hooked on to the eye of the needle, and drawn back with it through the tissues.

The steps of the operation are conducted as follows:—The patient being laid on his back with the shoulders well raised and the knees

* See Femoral and Ventral Hernia radically cured, by Redfern Davies, Med. Times, Feb. 12, 1859; (four cases of femoral and two of ventral hernia;) Mr. Spencer Wells's case, ib., Feb. 5, 1859.

bent, the pubes cleanly shaved, the rupture completely reduced, and chloroform administered, an oblique incision about an inch long is made in the skin of the scrotum over the fundus of the hernial sac. The knife is then carried flatwise under the margins of the incision, so as to separate the skin from the deeper coverings of the sac to the extent of about an inch or rather more all round. (See Fig. 11.) The

Fig. 11.

forefinger is then passed into the wound, and the detached fascia and fundus of the sac invaginated into the canal. The finger then feels for the lower border of the internal oblique muscle, lifting it forwards to the surface. By this means the outer edge of the conjoined tendon is felt to the inner side of the finger. (See dissection of parts in Fig. 12.) The needle is then carried carefully up to the point of the finger on its inner side, and made to transfix the conjoined tendon, and also the inner pillar of the superficial ring. When the point is seen to raise the skin, the latter is drawn over towards the median line, and the needle made to pierce it as far outward as possible. (See Fig. 13.) A small hook bent on the end of the wire is then attached to the eye of the needle, drawn back with it into the scrotum, and then detached. The finger is next placed behind the outer pillar of the ring, and made to raise that and Poupart's ligament as much as possible from the deeper structures. The needle is then passed along the outer side of the finger, and pushed through Poupart's ligament a little below the deep hernial opening. (See Fig. 14, dissection.) The point is then directed through the same

skin puncture before made, the other end of the wire hooked on to it and drawn back into the scrotal puncture as before, and then detached.

Fig. 12.

Next, the sac at the scrotal incision is pinched up between the finger and thumb, the cord slipped back from it as in taking up varicose veins of the cord. The needle is then passed across behind the sac, entering and emerging at the opposite ends of the scrotal incision. (See Fig. 15.)

The end of the inner wire is again hooked on and drawn back across the sac. Both ends of the wire are then drawn down until the loop is near the surface of the groin above; they are then twisted together down into the incision, and cut off to a convenient length. Traction is then made upon the loop. This invaginates the sac and scrotal fascia well up into the hernial canal. The loop of wire is then twisted down close into the upper puncture, and bent down to be joined to the two ends in a bow or arch, under which is placed a stout pad of lint. (See Fig. 16, A. and B.) The whole is held steady by a spica bandage.

The wire is kept in from ten days to a fortnight, or even longer if the amount of consolidation and adhesive action is not satisfactory. Very little suppuration usually follows, but after a few days the parts traversed by the wire can be felt thickened and hardened by adhesive deposit which blends together the sac, the pillars of the superficial ring, and the tendinous boundaries of the hernial canal into a resisting mass, the wire becoming more and more loosened by ulceration in its track, until it can be untwisted and withdrawn upwards.

In this operation the hernial canal is closed along its whole length, and an extended adherent surface is obtained to resist future protrusion.

A horseshoe pad is worn for a few months. It may then be laid aside, unless in exceptional cases, or when the patient is about to be subjected to violent strains or lifting.

For large cases of direct hernia, Mr. Wood crosses the wires in the canal, and obtains an additional hold upon the pillars of the ring below. The ring pad truss before described is also employed in these cases after the operation.

For small cases, and the hernia of children, he employs a pair of rectangular pins, one of which is made to traverse from above downwards the conjoined tendon and inner pillar and the other Poupart's ligament from below upwards. Both these pins are made to

enter and emerge at the same cutaneous aperture, without any incision of the skin. During their application the forefinger invaginates

Fig. 13.

the thin skin of the scrotum into the hernial canal, and thus protects the important deep-seated parts. The same structures are transfixed as described in the preceding operation. The pins are bent at a right angle near the blunt end, and provided with loops at the bent part (see Fig. 17, p. 579), so that each can be locked into the loop of the other, and then by a half turn can be twisted round so as to entwine closely the included structures, and cause them to adhere intimately as the pins ulcerate nearer to each other, and finally meet. By the oblique direction of the pins an adhesion along the whole length of the canal between the surfaces of the perforated sac, and the tendinous walls of the canal and pillars of the ring is insured.

Out of 100 cases of all kinds and every degree of severity of inguinal rupture, operated upon by this surgeon, no less than 68 have proved up to the present time satisfactory cures. Many of the patients were operated on five or six years ago, and in the less severe cases have worn no truss after the first few months. One only died. The fatal result occurred three weeks after the operation, from pyæmia then prevalent in the hospital. Most of those not entirely cured have been much improved, and a truss made available. None have been made worse by the operation.*

* In a case at which this surgeon lately assisted Mr. Walton, of St. Mary's Hospital, the patient died a week after from peritonitis. This case was of a

2. The *irreducible* inguinal hernia must be supported with a bag-truss. If it contain only *omentum*, a common truss is sometimes

Fig. 14. Fig. 15.

applied in the usual manner, so as to make the omentum adhere to and plug the neck of the sac. But this cannot often be borne, and is liable to induce swelled testicle. For these cases, a ring pad truss on Wood's principle, with an India-rubber water cushion, is the most comfortable and effective apparatus.*

3. In attempting the reduction of *strangulated* oblique inguinal hernia, the patient should be placed with his body bent forward, his pelvis raised, and his thighs as close together as possible (although the surgeon must put one arm between them), and the pressure must be made upwards and outwards.

The *operation* for this hernia is performed thus:—The parts being shaved, and the skin made tense, an incision three or four inches long must be made through the skin, along the axis of the tumour, beginning from above its neck. This will be quite long enough, even for the largest hernia; because the object is to bring the seat of stricture fully into view, without exposing too much of the sac. Then the sac-

very aggravated and exceptional character, an enormously large hernia with a very large opening into the cavity of the belly, and a lax and indefinite neck.

* Wood, On Rupture, Inguinal, Crural, and Umbilical. Robert Hardwicke, 192, Piccadilly.

cessive coverings, before enumerated, are usually divided in the following manner:—a little bit of each is pinched up with forceps, and

Fig. 16.

Fig. 17.

cut into with the knife held horizontally; a director is passed into this little aperture, and the layer is then divided on it to the extent of the incision in the skin. Cautious operators will find (or make) many more layers than those usually enumerated, which are, in fact, easily subdivisible, especially in old herniæ. But the practised surgeon, who knows that he is operating on the living body, and that his object is to cut through everything till he reaches the sac, will dispense with these dissecting-room formalities. When at last the sac is reached, which will be known by its bluish transparency, it is to be opened sufficiently to admit the finger, a little bit of it being first pinched up and cut through, so as to admit the director. Then the left forefinger should be passed up into the neck of the sac to seek for the stricture, which will generally be at the internal ring. It is usually at the deep ring, but may be at the external ring (or at both); but wherever it is, it must be dilated so as to allow the finger to pass into the abdomen. A curved blunt-pointed bistoury or hernia-knife—not cutting quite up to the point—should be passed up flat on the finger through the stricture, and its edge be then turned up so as to divide it; and in every case the division should be made *directly upwards*, parallel to the linea alba; and then whether the hernia be direct or oblique, the epigastric artery will not be wounded. If no stricture be discovered in the neck, it must be sought for in the body of the sac.

The subsequent proceedings—the return or otherwise of the intestine, and the after-treatment—are detailed in the preceding section.

If the surgeon perform the operation without opening the sac, the first point, says Mr. Luke, is to ascertain the exact seat of the stricture. Now, since the stricture prevents the communication of impulse from any one part of the tumour to any other part beyond the stricture, all that is required is, to press the tumour firmly between the fingers of one hand so as to cause impulse, whilst with the fingers of the other hand at the neck of the sac, the precise point where impulse ceases is ascertained. At that point will be found the seat of stricture. "The next step is, to incise the integuments so that the centre of the incision shall be directly over the stricture; a proceeding easily accomplished by causing a transverse fold to be pinched up between the fingers and divided by transfixing it with a straight bistoury, in a direction parallel with the long axis of the tumour. The various fascias are subsequently divided, until the neck of the tumour is fairly exposed. If this be carefully and completely done, a depression will usually be observed at the seat of stricture, presenting a more contracted appearance at that part than at others. To the touch this contracted part feels thick, while into it thin layers of fascia dip, which may be mistaken for the stricture itself, but which may be divided wholly independent of it, and no relief arise from the division. When these layers are turned back, the real stricture is exposed to view." Then the next step is, to scarify the thickened peritonæum forming the stricture, so as to render it dilatable, without actually cutting through it, and then the taxis is to be used for the return of the hernia. When the stricture is caused by the margin of the external ring, it is easily divided by the hernia-director and bistoury; when at the internal ring, it must be done by the same means, although the operation is more difficult.*

SECTION VII.—FEMORAL OR CRURAL HERNIA.

DEFINITION.—Femoral hernia is that which escapes behind Poupart's ligament.

It passes first through the *crural ring*—an aperture bounded internally by *Gimbernat's ligament*—externally by the femoral vein—before, by Poupart's ligament—and behind by the bone. It next descends behind the *falciform process* of the fascia lata; thirdly, it comes forward through the *saphenic opening* of that fascia; and lastly, as its size increases, it does not descend down on the thigh, but turns up over the falciform process, and lies on the anterior surface of Poupart's ligament. The *coverings* of this hernia are—1. Skin. 2. The *superficial fascia* of the thigh, loaded with fat, and divisible into an uncertain number of layers. 3. *Fascia propria*, a layer of cellular tissue derived from the sheath of the femoral vessels, blended on its superficial aspect with the *fascia cribriformis* which closes the saphenic aperture. It is in general pretty dense about the neck of the hernia, but thin, or even

* Luke, Med. Chir. Trans., vol. xxxi., p. 108.

deficient on its fundus. 4. The sac. Between the last two there is often found a considerable layer of sub-peritonæal fat, which might be mistaken for omentum.

Femoral hernia rarely attains a very large size. It is much more frequent in the female than in the male, obviously from the greater breadth of the pelvis, and greater span of the crural arch.*

DIAGNOSIS.—1. Femoral hernia may be distinguished *from the inguinal* by observing that Poupart's ligament can be traced over the neck of the sac, and that the spinous process of the pubes lies internal to and above it; whereas it is the reverse in the inguinal hernia. Supposing that a large femoral hernia is so fixed that it will not allow the course of Poupart's ligament to be traced, the diagnostic mark pointed out by James, of Exeter, may be attended to, to wit, that an inguinal hernia descends towards the labium, a femoral may mount upwards and outwards to near the spinous process of the ilium. This difference, according to Mr. Wood, is also found in the direction of the cough impulse. If the abdominal rings be examined, and found unoccupied by the tumour, all doubt as to its crural nature is removed.†

2. *Psoas abscess* resembles this hernia in its situation, in dilating on coughing, and diminishing when the patient lies down. The points of distinction are, that it is generally more external, that it fluctuates, but does not feel tympanitic, and that it is attended with symptoms of disease of the spine.

3. *Varix of the femoral vein* also resembles this hernia, inasmuch as it dilates somewhat on coughing, and diminishes when the patient lies down; but then if pressure be made below Poupart's ligament, the swelling quickly reappears, although it must be evident that under such circumstances a hernia could not come down.

Fig. 18.‡

* Mr. Partridge informed the author that he had met with a case of femoral hernia, protruding below Poupart's ligament, external to the vessels.

† James, On Operations for Strangulated Hernia, &c., London, 1859, p. 10.

‡ The cut, taken from a preparation of Mr. Fergusson's in the King's College

4. *Bubo and other tumours of the groin* may in most cases be recognised by their general character and history, and by their being unattended with symptoms of inflammation or obstruction of the bowels. But if there be any such swelling, and symptoms of strangulation as well, an incision should certainly be made to examine it; for there may be a tumour that may be satisfactorily proved to be an enlarged gland, and yet there may be a small knuckle of intestine strangulated behind it.

5. Lastly, the possibility of there being a strangulated *obturator hernia* behind the femoral hernia should not be lost sight of.

TREATMENT.—1. The *reducible* femoral hernia should be supported by a truss, the pad of which should tell against the hollow which is just inferior and external to the spinous process of the pubes. This hernia is very seldom cured radically; only a few cases are recorded.

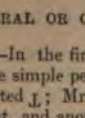
For *femoral rupture*, in suitable cases affecting young and healthy women, Mr. Wood has devised an operation by which a wire is made to traverse Poupart's ligament twice, across the neck of the hernial sac, fixing it firmly to the fascia lata covering the pectineus muscle inside the femoral vessels. This operation also is done without invagination of the skin, by a small incision, and the use of the same kind of needle and wire as in the operation for the inguinal variety, the after-treatment being the same as before described.

This surgeon, however, only recommends the operation in exceptional cases of femoral hernia in women, since their less laborious occupations, less necessity for muscular exertion, and more voluminous dress, render the use of a truss more convenient and effective than is usual in men.

2. The *irreducible* should be supported by a truss with a hollow pad; or perhaps (if it be omental) the pressure of a common pad may be borne.

3. The femoral hernia, when *strangulated*, gives rise to much severer symptoms than the inguinal does, because of the denser and more unyielding nature of the parts which surround the neck of the sac. In performing the taxis, the patient should be placed in the usual position, with the thigh of the affected side much rolled inwards, and crossed over towards the other side. The tumour should first be drawn downwards, from the anterior part of Poupart's ligament, and then be pressed with the points of the fingers backwards and upwards. If, however, the taxis and chloroform do not succeed, the operation should be resorted to.

Museum, shows a femoral hernia with its relation to the other parts which pass under Poupart's ligament. Externally are seen sections of the iliacus and psoas muscles, with the crural nerve between them; then the femoral artery and vein; next the hernia, which passes through a small aperture occupied by an absorbent gland in the normal state, and is bounded by Gimbernat's ligament on its inner side. The hernia passes downwards in the sheath of the femoral vessels, separated, however, from the vein, as that is from the artery, by a process of cellular tissue. The sheath of the vessels is continuous above with the fascia transversalis.

The old operation.—In the first place the skin must be divided. Some surgeons make one simple perpendicular incision. Sir A. Cooper directs one like an inverted ⅃; Mr. Liston prefers making one incision along Poupart's ligament, and another falling perpendicularly from its centre over the tumour, thus:  The skin may be very safely and expeditiously divided by pinching it up into a fold, and running the knife through it with its back towards the sac. Mr. Fergusson sometimes makes one like an inverted ⅄, so that the skin can be turned back in three flaps; after which the succeeding layers may be divided by a simple longitudinal incision. Then the different cellular layers down to the sac must be divided by the bistoury and director, as in the inguinal hernia, and the sac must be opened with very great care, because it is generally very small, and embraces the bowel tightly, and seldom contains any serum or omentum. Then the finger should be passed up to seek for the stricture, which, according to Sir A. Cooper and Mr. Liston, will be generally found to be the *inner edge of the falciform process*. This must be gently divided for a line or two, the incision being directed *upwards and a little inwards*, towards the spinous process of the pubes. It must be recollected, that if this incision were carried too far, the spermatic cord in the male, or round ligament in the female, would be injured. If, however, the stricture is not released by that incision, a few fibres of Gimbernat's ligament must be divided.

2. The operation without opening the sac is described by Mr. Luke thus. After premising that the seat of stricture is sure to be at or near the femoral ring, and that it is sometimes caused by bands of fascia propria, half or three-quarters of an inch below the ring; and that the upper boundary of the tumour on the abdominal surface is often marked by a visible depression, or at least that it can be felt by the fingers; "a fold of integuments," he continues, "is to be pinched up at that part, and divided by transfixing it with a narrow knife, so that the incision, when the skin is replaced, shall fall perpendicularly to the body, with its centre opposite to the depression referred to. By a few strokes of the scalpel the tendinous expansion of the abdominal muscle is to be laid bare; after which a finger should be introduced as far as Poupart's ligament, between the tendinous expansion and the tumour, where the latter rises upon the former. The ligament being thus exposed, a hernia-director is guided under it by the finger into the femoral ring, the margin of which may be safely and easily divided in an upward direction with a common probed bistoury, and the taxis applied in the usual way. Should the margin of the ring have formed the stricture, the taxis for the most part succeeds very readily, and the operation is completed in a very short time. But should the stricture be caused by the bands of fascia propria referred to, the director will have passed over them as it entered the femoral ring, in which case any amount of division in an upward direction will be of no avail. When the taxis does not succeed readily, these bands of fascia may generally be suspected to be the cause of failure. The fact may be made suffi-

ciently clear by introducing the finger upon the neck of the sac, under Poupart's ligament, while the body of the sac is pressed between the fingers and thumb of the other hand, when it will be discovered that no impulse is communicated to it by such pressure. By a little attention the bands may be detected crossing the neck of the sac from half to three-quarters of an inch below the ring, and may be divided by insinuating the nail of the forefinger of the left hand under them from above, and by carrying the point of a probed bistoury along the nail, with its blunt edge towards the sac. The division is made by the surgeon drawing the bistoury away from the sac towards himself, a proceeding which, if properly performed, avoids all danger of wounding the sac or its contents."*

3. *Mr. Gay's operation*, respecting which Mr. Fergusson says emphatically that he scarcely ever performs any other for crural hernia, and that, "if the sac is not opened, it is the nearest reasonable approach to the taxis that surgery has yet made," is thus performed: An incision, rather more than an inch long, is made near the inner side of the neck of the tumour. The superficial fascia having been divided, the forefinger (of the left hand if the hernial tumour is on the right side, and *vice versâ*) is to be passed through this wound, along and close to the side of the hernial tumour, to its neck. On the finger, a *bistouri caché* is to be passed through the cribriform fascia, and through the crural canal to the ring. "By the least amount of force, and with the aid of a little gentle compression of the inner side of the tumour by the finger, the point of the bistoury may be insinuated between the *sac* and the pubic margin of the *ring;* the edge of the knife is then to be turned towards the pubes, and by projecting the blade, the seat of stricture in that direction may be effectively divided." If, after this, and after the division of any other stricture that may be felt around the neck of the sac, the hernia cannot be reduced, the incision can be enlarged, and the operation of opening the sac, as usually directed, be performed.†

SECTION VIII.—THE UMBILICAL, VENTRAL, AND OTHER REMAINING SPECIES OF HERNIA.

I. UMBILICAL HERNIA—(*exomphalos*)—is most frequent in children soon after birth because of their incomplete development. It is also not uncommon in women who have frequently been pregnant, although, in many of the so-called umbilical herniæ in adults, the hernial aperture is really not at the umbilicus, but a little on one side of it. The coverings of this hernia are skin, superficial fascia, and sac; they are always very thin, and not unfrequently the sac is adherent to its contents. In infants the presence of a sac is not so well marked.

Treatment.—If *reducible*, and the patient an infant, the plan recom-

* Med. Chir. Trans., vol. xxxi., p. 112.

† On Femoral Ruptures, with a new mode of operating, &c., by John Gay, Lond., 1848.

mended by Cooper is to place a hemisphere of ivory with its convex surface on the aperture, and retain it there with cross slips of plaster, and a bandage round the belly. The objection to this is that the convexity of the pad is very apt to slip out of the aperture, and so be ineffective; while, on the other hand, if it be held effectively tight, it is not only inconvenient, but tends to dilate the aperture and keep it open. A pad of linen, covered with a round flat disc of sheet lead, will do as well. An adult should wear a truss or elastic belt, with some contrivance to prevent it from slipping down below its proper level.

Mr. Wood has devised a pad for umbilical rupture which, like his trusses for inguinal and femoral herniæ, is constructed upon the principle of applying the pressure at the margins of the ring, tending to close them, instead of in the centre, tending to keep them open.

This pad is made of a cylinder of india-rubber or gutta percha arranged in an oval ring, the centre opening being closed by an obturator made either of sheet india-rubber, or, in difficult cases, a plate of hard metal or ivory, flat and level. The ring is fixed under a broad elastic body belt, held in place by a shoulder-strap if necessary. The effect of the belt passing over the edges of the ring pad is to cause it to press backwards and inwards so as to close the opening.* (See Fig. 19.)

Fig. 19.

This truss has been worn in many cases, both in the adult and infant, with entire success. This surgeon has also operated with success for the radical cure of umbilical hernia which had resisted the methods of treatment by pressure. The operation consists simply in applying subcutaneously silver-wire sutures to the tendinous margins of the hernial opening so as to draw them together and cause their adhesion.†

For the irreducible umbilical hernia a large hollow pad should be worn. If it become strangulated, and the patient is aged, and the strangulation were preceded by constipation, purgatives and copious enemata should have a fair trial. If the operation be necessary, an incision should be made over the neck of the tumour through the skin (which is very thin), and the tendinous parts be divided, and the bowels returned without opening the sac, if possible.

II. VENTRAL HERNIA is that which protrudes through the *linea alba*, or through the *lineæ semilunares* or *transversæ*, or, in fact, through any other parts of the abdominal parietes, save those which

* Wood, On Rupture, page 259. † Op. cit. page 251.

are the ordinary seats of hernia. It may be a consequence of wounds or bruises. Its treatment requires no distinct observations; but if it should ever be necessary to operate for the relief of strangulation, care must be taken to avoid the epigastric artery.*

III. PERINÆAL HERNIA descends between the bladder and rectum, forcing its way through the pelvic fascia and levator ani, and forming a tumour in the perinæum.

IV. VAGINAL HERNIA is a variety of the preceding, in which the tumour projects into and blocks up the vagina, instead of descending to the perinæum.

V. LABIAL or PUDENDAL HERNIA, another variety, descends between the vagina and ramus of the ischium, and forms a tumour in one of the labia. It is to be distinguished from an inguinal hernia which has descended into the labium, by the absence of swelling at the abdominal rings. These three herniæ must be replaced by pressure with the fingers, and be kept up by pads made to bear against the perinæum, and perhaps by hollow caoutchouc pessaries worn in the vagina.

Fig. 20.†

VI. OBTURATOR or THYROID HERNIA projects through that aperture in the obturator ligament which gives exit to the artery and nerve. In a fatal case related by Mr. Howship, in which a very small piece of

* Mention is made in the Lond. Med. Gaz., 21st Oct., 1842, of an adipose tumour, situated between the peritonæum and abdominal muscles, and projecting through an aperture in the linea alba, through which it could be pushed back, so that it completely simulated a hernia. Such a case, if complicated with peritonitis, might render the diagnosis very obscure; but an incision would clear up the mystery.

† From a preparation of Mr. Fergusson's in the King's College Museum.

intestine was strangulated in this opening, the patient complained of great pain down the leg in the course of the obturator nerve. This might be an aid in the diagnosis. In a case in which Mr. Hilton laid open the abdominal cavity, and disengaged a knuckle of intestine from the obturator foramen, there were no symptoms that indicated the kind of obstruction met with.* In a case successfully operated upon by Mr. Obrè there were symptoms of strangulation, and a slight degree of fulness in the triangular space at the upper part of the right thigh compared with the left; and a distinct hardness in the neighbourhood of the femoral artery behind the saphenous opening. Mr. Obrè made a straight incision, as in the operation of tying the common femoral artery, beginning three inches below Poupart's ligament, hoping to find intestine low in the crural canal. When the cribriform fascia was opened, and the saphenous opening exposed, no hernial sac was found, but a hard something could be felt lying deep on the inside of this opening. The dissection was continued downwards: the fascia lata divided; the pectinæus exposed and divided transversely for about an inch and a half, when a hernial sac was exposed, which rose up into the wound to the size of a pigeon's egg. The finger was passed into the obturator opening; the sac opened, and found to contain small intestine; the edge of the aperture slightly divided, (in doing which the saphenic vein was wounded, and was tied,) the intestine was returned, and the patient did well.

VII. ISCHIATIC HERNIA protrudes through the sciatic notch. This and the preceding are exceedingly rare; and the tumours are of necessity small. If discovered to exist during life, they must be returned and supported by proper apparatus—and if strangulated, the stricture must be divided by operation.

VIII. DIAPHRAGMATIC HERNIA is generally a result of congenital deficiency, or accidental separation of the fibres of the diaphragm. But it may also be caused by violent falls on the abdomen, or by violent pressure of any kind, capable of lacerating the diaphragm, and driving some of the bowels into the thorax.† It may also be a consequence of gunshot or lance wounds. This form of hernia, if strangulated, will produce the ordinary symptoms—vomiting, constipation, and pain; and the distinction from the symptoms of ileus or intussusception—or from those produced when a fold of bowel is entangled in a rent in the omentum, or mesentery; or when the bowel is constricted by membranous bands resulting from previous inflammation of the peritonæum, will be very difficult, if possible. In a case recorded by Dr. Copeman, of Norwich, the patient had umbilical hernia, which was quite free from strangulation, but a portion of the stomach and omentum had escaped, through a rent in the diaphragm, into the left pleural cavity.

* This case, like most others, was unfortunately operated upon too late. The obstruction existed from the 20th January to the 1st February. Hilton, Med. Chir. Trans., vol. xxxi., p. 323; Obrè, Ranking, vol. xiv.: Report of cases in Lancet, for 1851, vol. i., p. 512; Wilkins, Lancet, 1853, vol. i.

† Reid on Diaphragmatic Hernia, Edin. Med. and Surg. Journ., Jan. and July, 1840; Copeman, Prov. Med. Journ., 1855.

This patient complained of pain in the left shoulder, and below the heart, and dyspnœa.

Mr. Guthrie had predicted, in his Commentaries,* the possibility of hernia through the diaphragm, after a gunshot wound, and had described the operation which might be attempted for its reduction: that is, an incision through the walls of the abdomen, large enough to admit the hand to draw back the stomach into its proper place. He informed the writer (Jan. 1856) that he had received from the Crimea an interesting account of a gunshot wound, in which the greater part of the stomach and duodenum protruded into the chest through a wound of the diaphragm caused by a Minié ball. A similar case is described in Williamson's Military Surgery, page 91.

CHAPTER XIX.

SURGICAL DISEASES AND INJURIES OF THE RECTUM AND ANUS.

I. FOREIGN BODIES in the rectum sometimes require to be removed by surgical art. They may consist either of small bones or the like that have descended from above, or of pins, glyster-pipes, or other bodies introduced from below. Substances of very extraordinary dimensions (a blacking-bottle, for instance) have been forced into the anus. The grand point is first to dilate the bowel well, by passing in several fingers coated with lard, or by means of a speculum, and then a proper forceps, or a lithotomy scoop, may generally be used with success.

Several *specula* have been invented for the purpose of enabling the surgeon to see into the anus; to remove substances from within, or to make medicinal applications, or to perform operations. The simplest is a glass tube, silvered and covered with caoutchouc, of various sizes, and having various kinds of apertures to allow of the inspection of the mucous membrane. This was invented by Mr. W. Fergusson. A very complete three-valve speculum has been devised by Mr. Lane, and is made by Savigny. Others are made by Coxeter, and other mechanicians.

II. IMPERFORATE ANUS (*Atresia ani*) signifies a congenital closure of the rectum, and may occur in various degrees. The anus may be merely closed by thin, fine skin, which soon becomes distended with meconium; or the gut may terminate in a blind pouch at any point from the sigmoid flexure downwards, the anal aperture being altogether wanting; or the anus may be open for an inch or two, with an obstruction beyond; or the rectum may terminate in the bladder, or urethra, which will be known by the escape of urine tinged with meconium; or,

* Sixth ed., 1855, p. 505.

although the anus may be closed, there may be a fistulous track leading from the rectum just above it, and opening somewhere in the perinæum.*

† Imperforate anus. From the King's Coll. Museum.

Treatment.—If the end of the intestine can be felt protruding when the child cries, a free crucial incision may be made into it without delay: if it cannot be felt, a day or two should be waited, so that it may become distended with meconium, and then a cautious incision should be made with a double-edged bistoury, in the direction of the curve of the sacrum. If it succeed in reaching the bowel, the aperture should be kept open by a bougie.

But if this operation should fail in reaching the bowel, or if the rectum appear to be altogether deficient, the only resource is the *formation of an artificial anus* in the left loin (p. 550). When the rectum opens into the bladder or urethra, an aperture must be made into the neck of the bladder for the free discharge of the fæces,‡ if the natural orifice cannot be restored.

III. Spasm of the Sphincter Ani is known by violent pain of the anus, with difficulty of evacuating the fæces. On examination, the muscle feels hard, and resists the introduction of the finger. This affection may be caused by constipation of the bowels, or disorder of the health. It may occur in sudden paroxysms which soon go off; or

* Case in South's Chelius, vol. ii. p. 329.

‡ Case in Fergusson's Pract. Surg., 3rd ed., p. 720.

may last permanently, and lead to organic thickening and stricture of the anus. It is very frequently connected with piles, or with fissure of the anus, or ulcer just within it.

PROCTALGIA, or neuralgia of the anus, is a very common disorder of children and of gouty adults, and in either case is best treated by purgatives.

IV. FISSURE OF THE ANUS is a small chap, or crack, or ulcer, giving intense pain during the passage of the motions, frequently continuing two, four, or even eight hours after the evacuation. Introduction of the finger causes greater suffering in this than in any other affection of the rectum. A piece of hypertrophied skin, probably the remains of an external pile, and generally situated behind, leads, in many instances, to the fissure. Immense relief is produced by free purgation. If, after a fair trial of purgatives, and the local use of sulphate of copper, nitrate of silver, or of tannin lotion, or ointment of galls with lead, the symptoms continue unabated, recourse must be had to the knife. (See next paragraph.)

V. ULCER OF THE RECTUM, if influenced by the sphincter muscle, is seldom cured without the use of the knife. If, however, it be situated at a distance, and out of reach of the action of the muscle, it may heal up by the local application of stimulants, and attentive regulation of the bowels.

In the first place, probably a dose or two of calomel, followed by castor-oil, should be administered, and after this blue pill, dandelion, nitro-muriatic acid, and such other remedies as may be necessary to bring the secretions, especially those of the liver, into a healthy condition. 2. Meanwhile, an attempt may be made to soothe the local irritation by washing out the rectum with a pint of thin arrowroot and water after a motion; or by injecting, by means of a glass syringe, about two fluid drachms of purified glycerine; or by using a lotion of borax and extract of poppies, F. 122, or belladonna liniment, F. 149. 3. Stimulating applications, such as nitrate of silver and citrine ointment, may be tried to the fissure or ulcer. 4. Other means failing, an incision should be resorted to. The left forefinger should be introduced, and a straight, narrow, blunt-ended bistoury by its side; with the latter, an incision should be made through the fissure, or ulcer, so as to divide the mucous membrane, and in severe cases, part of the sphincter. A little flake of cotton wool should then be laid in the wound, so that it may heal by granulation.*

VI. HÆMORRHOIDS, or PILES, are small tumours situated near, usually within, the anus. They consist of folds of mucous and submucous tissue in various stages of inflammatory swelling, congestion, infiltration, or permanent hypertrophy, and usually contain enlarged veins.

Sometimes there is a little varicose knot with the cellular tissue around thickened. Sometimes the blood in a dilated vein coagulates,

* See observations by Richard Quain, F.R.S., quoted in Ranking's Abstract, vol. xvi.

forming a solid tumour with the thickened cellular tissue around. Again, the mucous membrane of the whole circumference of the bowels becomes swollen and hypertrophied, with its surface extremely vascular and sensitive. This swollen membrane is apt to become prolapsed, or, in plain English, to come out at every evacuation of the bowels; causing great pain from being compressed by the sphincter until fairly put back into its place, and bleeding freely from the straining and pressure; or there may be a formation of erectile tissue, chiefly made up of capillaries, and bleeding freely when touched and after evacuation of the fæces. Lastly, there may be one or more distinct pendulous tumours, varying in size from that of a pea to that of a walnut, of a pale or reddish-brown colour when indolent, but dark or bright red when congested or inflamed. These add greatly to the discomfort and tendency to prolapse.

External Piles may be met with, 1, in the form of round hard tumours just at the margin of the anus, and covered half with skin and half with mucous membrane; or, 2, of oblong ridges of skin external to the sphincter, commonly called *blind piles*.

Symptoms.—Piles may be met with in two states—*indolent* or *inflamed*. When *indolent*, they produce the inconveniences that necessarily result from their bulk and situation, and from getting within the gripe of the sphincter; more or less pain in defæcation; prolapse; and if not pain, yet a sense of weight and discomfort that is excessively annoying, and that renders the mind inapt for matters requiring deep thought. Sometimes, too, the bowel is apt to come down when the patient is taking exercise or exerting himself. When *inflamed*, they occasion the following symptoms: Pain, heat, itching, fulness, and throbbing about the anus—a sensation as if there were a foreign body in the rectum—pain and straining in passing evacuations. These symptoms may, in violent cases, be complicated with irritation of the bladder, frequency of micturition, pain in the back, pain and aching down the thighs. The young surgeon should remember, that a patient with piles may not be aware of the nature of his complaint, or through delicacy may abstain from mentioning it. Whenever, therefore, a patient complains of unusual irritation of the bladder, or of symptoms of dysentery—that is to say, frequent, painful, and unsatisfactory efforts to pass motion—the surgeon should always make inquiries after piles. In women, piles may cause aching of the back, uterine irritation, with mucous discharge, and many anomalous symptoms, which the surgeon will in vain endeavour to cure until he finds out the real cause. The hæmorrhage from piles will be treated of more particularly at p. 595.

* Piles after excision, showing the dilated veins, of which they are in a great measure composed.

Causes.—The *predisposing causes* are any circumstances that produce fulness of the abdominal vessels, or that impede the return of blood from the rectum—such as luxurious and sedentary habits of life—pregnancy, habitual constipation, and disease of the liver. The *exciting causes* may be anything that irritates the lower bowels—particularly straining at stool—and violent doses of purgative medicines; among which aloes is blamed more than it deserves to be. Since this medicine is so valuable and in such common use, and yet so little understood, the writer will, for the sake of his younger readers, state briefly what the use of aloes is, and in what its misuse consists. Aloes is what was formerly called *ecoprotic;* that is, an expeller of fæces. When taken into the stomach it is readily dissolved and absorbed, and is eliminated through the colon and rectum, which latter parts it stimulates to unload themselves of their contents; and if they contain fæcal matter, which from torpidity they do not expel, aloes is an effectual and unirritating remedy. But if these parts are already active and empty, aloes can but irritate them fruitlessly, causing straining and tenesmus, and also probably piles. Lastly, piles are most frequent in women, and are rare under puberty.

General Treatment.—The grand objects are to remove the predisposing and exciting causes. The patient, if stout, plethoric, and of sedentary habits, ought to live abstemiously, and take plenty of exercise. The bowels should be regulated by some mild aperient, capable of producing daily copious soft evacuation without straining or griping. Senna, sulphur, cream of tartar, and magnesia, in the form of electuaries, F. 46—55, or compound colocynth pill, are frequently used for this purpose; or pills of rhubarb and soap, with ipecacuanha, taken twice a day, F. 52; or a small dose of castor-oil or Pullna water, F. 42, in the morning. It is a good plan to inject the rectum with cold water both before and *after* the motions. In some cases it is advisable that the patient have his regular daily evacuation at night, just before bedtime, so that the prolapsed and irritated parts may have time to become quiescent during the night. In cases of long standing, in which the mucous lining of the rectum is relaxed, cubebs, or Ward's paste, or the confect. piperis. comp., may be given with great benefit in doses of ʒj ter die. In similar cases, especially if the patient is advanced in years, and the piles are attended with a flow of mucus, copaiba may be given in the dose of thirty or forty drops every morning in milk; and a scruple of common pitch may be taken in pills every night at bedtime. Old people rarely dislike the taste of copaiba.

If the *piles are inflamed*, leeches to the anus, or cupping on the sacrum, a dose of calomel and opium at bedtime, followed by castor-oil in the morning; low diet, rest in bed, warm hip-baths, fomentations, and poultices. Cold lotions of lead, with a little laudanum, may be substituted for the warm applications, if more comfortable. If there is a tense, bluish, solid tumour, evidently containing coagulated blood, it *may* be punctured; but perhaps it is better not to do so.

Local Treatment.—Having by the general treatment provided as far as possible against the original causes of the malady, it is the surgeon's duty to use such local measures as shall tend to restore the part to a healthy condition; amongst which we shall mention, 1. *perfect cleanliness.* The anus should be well washed with soap and water after each motion; and if the piles are internal, and protrude during evacuations, they should be washed before they are returned.

2. *Astringents.*—The zinc lotion, F. 117; or iron lotion, which is particularly recommended by Mr. Vincent, F. 128; or lotions of alum or tannin, of either of which a drachm or two may be injected into the anus after each motion, and be allowed to remain; the gall ointment, with or without lead, F. 162, and creosote ointment—are often of benefit. Dr. Burne recommends an ointment composed of pulv. hellebori nigri ʒj. adipis ℥j., which he says never fails of affording great relief, although exceedingly painful for a time. An ointment of a drachm of black oxide of mercury to an ounce of lard has also received high recommendations.

3. *Pressure* by means of a bougie introduced occasionally, or a firm pad of flannel, covered with oiled silk; or a pad of smooth wood or of ivory, made to bear up well against the anus by means of a stout perinæal or T bandage (see Bandages), or by means of a spring like that of a truss, is often of service. There is an instrument consisting of a short egg-shaped ivory bougie, which is introduced into the anus, and which is attached by a slender neck to an ivory pad; so that pressure is thus made both internally and externally: this may be useful in cases of internal piles with relaxed mucous membrane and tendency to prolapse, when no measure for removing the piles is thought advisable.

4. *Nitric Acid.*—All the above measures are preventive or palliative, and if they do not succeed, it is better to adopt some radical remedy. The first in order is the nitric acid; a most safe, speedy, and effectual remedy in the proper case, first introduced by Dr. Houston of Dublin. It is adapted for destroying a diseased *surface*—not solid tumours—but any patch of tender, tumid, and bleeding surface of mucous membrane which is the source of irritation and hæmorrhage. The operation is performed as follows:—The bowels having been just previously cleared, the patient must be told to protrude the piles; and if he cannot do it easily, he should sit over a vessel of warm water, or have an enema of warm water. The diseased surface is to be wiped with lint; and a portion of it, the size of sixpence, to be deliberately *dabbed* with a smooth wooden stick dipped into the concentrated acid. When this has taken effect, any superfluous acid is to be mopped up, lard is to be applied copiously, in order to prevent the caustic being too widely diffused, and the parts are then to be returned within the sphincter. The patient should go to bed, and the bowels be kept quiet—if necessary by opium—for forty-eight hours; and when the slough caused by the acid separates, the surface generally cicatrizes speedily, and leaves the

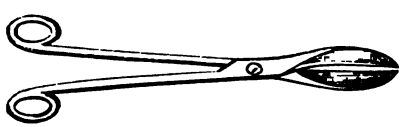
part braced up and contracted. It is difficult to exaggerate the benefits of this plan of treatment. It seldom causes pain or any ill consequences. The author has by two applications of it relieved a patient permanently of pain and hæmorrhage which had lasted for years, and which on the average caused him to lose two hours' time every morning, by rendering him incapable of attending to anything save his own miserable sensations. When the parts cannot be protruded, the acid may be applied through the speculum.

5. *The Ligature.*—But the acid will not be a sufficiently potent remedy if there are one or more actual tumours, or if a large track of mucous membrane is swelled and protrudes. For such cases, any tumours, together with a portion of relaxed mucous membrane, should be extirpated, and the ligature is the usual means of effecting it. Although the removal of piles need not be such a bugbear as some persons make it, yet the surgeon should pause if there be any organic disease of the liver or kidneys; and the patient should be put into the best state of health possible.

The piles are to be protruded as before; then (the patient having chloroform to render him unconscious of pain, and to relax the sphincter) the piles may be seized one by one and drawn out, and a small fine piece of hempen twine be tied as tightly as possible round the base

of each. They may be seized with any forceps; but one like that here depicted is very convenient. But it is better, especially if the tumour is large, to pass a double ligature through its base with a needle, and tie either half separately. Before finally tightening the ligatures, the piles should be slightly punctured. Any fold of superfluous membrane should be similarly seized and dealt with; and the surgeon should take care, whilst about it, to tie up enough; to tie it in small portions so that it may quickly slough off; and to tie it so tightly as to kill it at once. After the operation, the ends of the thread should be cut short, and be returned into the rectum. The patient should remain in bed, and the bowels should not be disturbed for forty-eight hours after the operation. Pain is to be relieved by an opiate, F. 32; and if it persist, the ligatures should be examined to see whether they remain as tight as possible, and if not, they should be reapplied.

Excision is the proper remedy for external piles. Any very large ose ridge of skin around the anus may at the same time be re- d with the scissors, and the edges of the cut be brought together fine suture. To apply the ligature to the skin is barbarous. For al piles, mere excision is dangerous, as the patient might bleed to . It may, however, be done safely thus:—The tumour having protruded, the base of it should be transfixed by a long needle, will prevent it from returning into the anus. Then it may be ; and the cut surface being exposed to the air, will not bleed, or does, it is easy to apply cold, astringents, or ligatures. After e hours the needle may be removed, and the part allowed to go Mr. Henry Lee has adopted a plan of seizing the part to be re- d between the blades of a sort of curved forceps, and cutting it hen touching the cut surface with nitric acid, or, still better, with on at a black heat. The pressure of the forceps prevents all ng at the time, and the caustic not only prevents it afterwards lso renders the patient more safe from pyæmia, hastens the cure, aves the parts more braced. Mr. Henry Smith employs for his se an ingenious clamp with a screw.*



Wood employs a spoon-shaped forceps, so as to prevent the of the acid; and when he seizes the fold of membrane to be d, he holds the forceps with its long axis parallel with that wel, so that any subsequent contraction of cicatrix may not he calibre of the bowel. If the tumour be very large, he ough it, from side to side, beneath the blades of the forceps, ligature, leaving one end hanging out at the anus; thus the wound are hindered from gaping when the forceps is removed. lan may be adopted of cutting through the mucous mem- ie base of the pile, so as to make a groove in which the s, and to shorten the process of separation. The most t of the pile is left, and this may be tightly tied by one still better, be transfixed and tied in two portions.† The be used in some cases.

TS and CONDYLOMATA. See p. 225.

ORRHAGE from the rectum is a very frequent concomi- and may be of two kinds. In the first place, it may be bursting of a varicose vein: in which case the blood is he hæmorrhage in general occurs at once in considerable

* Described in Lancet, Oct. 4, 1863.

† Curling On Rectum, 3rd edit., 1863, p. 54.

quantity; and may never occur again. This form is rare. But far more frequently it proceeds from the vascular surface of internal piles, which gives way under the straining which accompanies defecation. In the latter case the blood is arterial; it is squirted from the anus in jets when the patient is straining at the water-closet, and the bleeding occurs very frequently, especially when the patient is feverish, or the bowels disordered, or the piles inflamed. Hæmorrhage from the rectum may be distinguished from that which has its source higher up by noticing that the blood is generally of a florid hue, and that it covers the fæces, but is not intimately mixed with them.

Treatment.—1. If the hæmorrhage is moderate in quantity, if it has been of habitual or periodic occurrence, if it induces no weakness, and if it brings relief to pain in the head or any other feeling of disorder, before suppressing it the patient must be made to adopt a course of exercise, temperance, and aperient medicine. 2. But if the patient is weak and emaciated; if the lips are pale, and the pulse feeble, the bleeding should be at once suppressed. (We may observe here, that whenever a patient applies for relief in consequence of violent palpitations and shortness of breathing, or giddiness and swimming in the head—if the lips are pale, and the extremities tend to swell—the surgeon should always inquire for piles, because, as we before observed, some patients, through false delicacy, will not mention them.) Or if the bleeding, as sometimes happens, instead of relieving symptoms of heat and fulness in the rectum, aggravates them, it should be stopped, whatever the patient's complexion may be; and if he is of a full habit, he should live abstemiously, and keep the bowels open. The means of checking hæmorrhage from the rectum are, 1. That piles, if any exist, should be tied or cauterized with the aid of a clamp. This is the remedy—direct and surgical. 2. Astringent applications, such as injections of dec. quercus, or F. 128. 3. The internal remedies most likely to be of service are salts of iron or bark with sulphuric acid, or the balsams of copaiba and Peru. F. 9, 13, 14, 186, &c. 4. In order to stanch violent bleeding, the anus may be distended with a speculum, and any bleeding vessel be tied, or touched with a heated wire. Or the anus may be plugged.*

IX. DISCHARGE OF MUCUS—clear and viscid—without fæcal odour, may be caused by piles, ascarides, the use of aloes, or any other causes of irritation to the rectum. To be treated by mild aperients, astringent injections, and copaiba or cubebs. F. 37, 39, 13, &c.

* In severe bleeding, occurring after an operation on the rectum, after the failure of more ordinary means, a plug of the following description may be used. A good-sized conical cork, with a string passed through its centre, is to be placed in the rectum, then graduated circular pieces of lint penetrated by the string must follow: two or three pieces of lint can be passed at a time, and the entire number must be sufficient to form a good-sized conical plug, which is prevented from floating about in the rectum by traction on the string. Firm pressure over a large space can be obtained by the adoption of this method. For this note, the author is indebted to Mr. Sharman, some time of St. Mark's Hospital, now of the London Hospital.

X. ABSCESSES near the rectum may be caused by the irritation of foreign bodies, or by caries of an adjacent bone, but they are much more frequently the result of the various causes of disordered circulation in the hæmorrhoidal vessels that were mentioned as producing piles, and especially of that morbid state of mucous membrane which accompanies pulmonary tubercle or the tendency thereto. They may either be large and deep-seated, or small and superficial. 1. Deep-seated abscesses are attended with great aching and throbbing, difficulty and pain in evacuating the fæces, and fever, and on internal examination an elastic ill-defined tumour or fluctuation may be felt. If these abscesses are left to themselves, a vast quantity of matter may accumulate in the loose cellular tissue of the pelvis, and severe irritative fever result from its confinement. 2. Superficial abscesses are attended with more or less pain, tenderness, and throbbing, and swelling around the anus. Or either may be quite chronic and indolent.

Treatment.—In acute cases leeches and fomentations may be tried at first; but if they do not very soon remove the pain and tenderness, or if there is the least suspicion that matter is forming, a bistoury should be pushed home into the inflamed part, and if it be at all extensive, two or three punctures or counter-openings in the most depending parts, or where pointing occurs, should be made.

XI. FISTULA IN ANO signifies a fistulous track by the side of the sphincter ani. It is extremely difficult to heal, both because the constant contractions of the sphincter and levator ani interfere with the union of its sides, and because of the passage of fæcal matter into it from the bowel. There are three kinds spoken of in books. 1. The *complete fistula*, which has one external opening near the anus, and another into the bowel above the sphincter, where it may be felt like a small papilla. 2. The *blind external fistula*, which has no opening into the bowel, although it mostly reaches its outer coat. 3. The *blind internal fistula*, which opens into the bowel, but not externally, although its situation is indicated by a redness and hardness near the anus; or perhaps the aperture is so small as to be scarcely perceptible.

This affection is a common result of abscess by the side of the rectum. Brodie's opinion is, that it always commences with an ulceration of the mucous membrane of the rectum, and an escape of fæcal matter into the cellular tissue, which gives rise to abscess, and the abscess to fistula. But most other surgeons believe that it may be the result of abscesses around the anus, which have no connection with the rectum. Besides, there may be openings near the anus, leading from the tuber ischii, which may be carious.

Treatment.—The grand remedy for this affection is division of the sphincter ani, so as to prevent contraction of that muscle for a time, and division likewise of the internal orifice, if any. The digestive organs and secretions must first be put into good order, and the bowels be well cleared by castor-oil and an injection, so that they may not want to be disturbed for two or three days. *Operation.*—The patient being placed on his knees and elbows on a bed, or being made to kneel

on a chair and lean over the back of it, or lying on his side close to the edge of the bed, and the nates being kept asunder by an assistant, the surgeon introduces his left forefinger into the anus, and at the same time explores with a probe the whole extent and ramifications of the fistula. If it is of the *blind internal* kind, its situation must be ascertained, and a puncture be made into it by the side of the anus. Perhaps a probe bent at an acute angle may be passed into it from the bowel, and serve as a guide for the puncture. Then, one forefinger being still in the anus, the surgeon passes a strong curved probe-pointed bistoury up to the further end of the fistula. Next (if the internal opening cannot be found) he pushes it through the coats of the bowel, so that its point may come in contact with his forefinger. Then he puts the end of his forefinger on the point of the bistoury, and draws it down out of the anus; and as soon as it is fairly emerged, he pushes the handle towards the orifice of the fistula, so as to divide skin, sphincter, and bowel at one sweep. Sir B. Brodie recommends that the bistoury should always be passed through the internal opening of the fistula, and says that the affection will very likely return if this is not divided; he also condemns the practice of cutting through the bowel higher up than this opening; but all ramifications and burrowings of the fistula under the skin should be slit up. A little flake of cotton is then to be placed in the wound, and the patient to be kept in bed for three days. The subsequent treatment consists in the use of perfect cleanliness, and the daily introduction of a little flake of cotton (which may be dipped in some stimulating lotion if necessary) between the edges of the wound for the first few days, so as to prevent its edges from uniting, and to cause it to granulate from the bottom. If hæmorrhage prove violent after this operation, and does not yield to the application of cold or a bit of matico leaf, the anus must be well dilated with a speculum, so as to expose the bleeding surface to the air, and any artery discernible may be tied; or else it may be firmly plugged with lint, which is to be secured by a T bandage.

If the patient will not submit to this operation, or if he is labouring under disease of the lungs or liver or kidneys, in an advanced stage, so that it would be unsafe, the treatment must be *palliative* merely. The confect. piperis, or copaiba and tonics, may be administered internally, and stimulating injections and ointments be applied to the fistula. Luke's operation of cutting the fistula by ligature may be adopted by any one who is fond of variety, or whose patient fears the cold knife.

XII. PROLAPSUS ANI consists in an eversion of the lower portion of the rectum, and its protrusion through the anus. It is not merely that a fold of the mucous membrane protrudes; but that the muscular coat, and whole thickness of the bowel come down. This affection is most common in infancy and old age. It may depend on a natural laxity and delicacy of structure, or be caused by violent straining, in consequence of costiveness, or of the existence of piles, or stone, or stricture.

Treatment.—Whenever the protrusion occurs, the parts should be

carefully washed, and then be replaced by pressure with the hand. If there is any difficulty in doing so, the forefinger, oiled, should be pushed up into the anus, and it will carry the protruded part with it. If, however, as sometimes happens, a larger portion than usual has come down, and it is so swelled and tender from the constriction of the sphincter, and from being irritated by the clothes, that it cannot be returned, the patient should be put under chloroform, and so reduction be effected; but should the prolapsed portion come down again, the patient must keep in the recumbent posture, and assiduously apply iced water. In other cases, leeches, fomentations, and a dose of calomel and opium may be requisite. To keep the bowel up, it is a good plan, especially in children, to press the nates together with the forefinger and thumb, and to carry a broad strip of adhesive plaster from one side to the other, to be kept on till an evacuation is desired, and then replaced.

To cure this affection radically, the bowels should be so regulated as to prevent costiveness and straining; injections of dec. quercus, or of F. 128; sponging with cold water—tonics, especially steel, and support by pads and T bandages, may be used to give tone to the parts. Dr. MacCormac of Dublin recommends that when the stools are passed, the skin near the anus should be drawn to one side with the hand, so as to tighten the orifice. If the prolapsus be combined with piles, that which extirpates them will probably cure it. Otherwise two or three folds of the flabby mucous membrane on the protruded bowel may be pinched up with forceps, and tied tightly with ligatures. 2. Or ligatures may be passed by needles through several folds of skin just at the margin of the anus, which are then to be tied up tightly. Or 3, a small patch of relaxed mucous membrane may be destroyed by acid. Either of these operations may be repeated as often as necessary. Their effect in producing adhesion and consolidation of the relaxed tissue must be obvious. There is a French operation, which consists in excising a portion of the sphincter ani; but when this

* This cut, from a preparation in the King's College Museum, shows a section of a prolapsed rectum—the whole circumference of the lower part of the bowel being everted and extruded. The mucous membrane is excessively thickened from the irritation of exposure.

operation used to be performed (as it commonly was sixty years ago) for fistula, it was often followed by inability to retain the fæces.

XIII. INTERNAL PROLAPSUS, or INVAGINATION OF THE RECTUM.—When the rectum in women has become distended, and has lost its tone from protracted constipation and the abuse of warm enemata, the upper part of the bowel is apt to come down within the lower, and to be gripped by it after the manner of an invagination. This state of things causes great distress, constant feeling of weight and of desire to pass motions, and difficulty in so doing. On examination with the finger, the canal of the rectum is found obstructed by a tumour with a capacious *cul de sac* around it, and with the natural passage of the bowel in its centre. The writer has reason for believing that some degree of this affection is not very uncommon amongst women.

Treatment.—Aperients, such as rhubarb, with cubebs or cinnamon; or with small doses of nux vomica: mild astringent injections, and the bougie; the point of which should be carefully guided into the orifice in the centre of the prolapsed portion.*

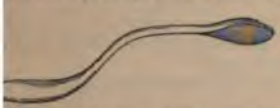
XIV. SPASMODIC STRICTURE of the rectum—known by great difficulty in evacuating the bowels, with spasmodic pain on doing so—is a rare affection. "It generally depends," says Mr. Mayo, "on a vitiated state of the secretions; and is more frequently relieved by a regulated diet and alterative medicines, and the use of injections, than by the employment of the bougie." (See *Proctalgia*.)

XV. PERMANENT STRICTURE.—In this affection there is a chronic thickening and contraction of the mucous coat of the rectum, so as to form a ring encroaching on its canal. It is generally situated at from two inches and a half to four inches from the anus. More rarely it is met with higher up, or even in various parts of the colon. It may follow the contraction of cicatrised ulcers. The *symptoms* are great pain, straining, and difficulty in voiding the fæces, which are passed in small,

* This malady is particularly described by Earle, Med. Gaz., vol. v.; Chevallier, Med. Chir. Trans., vol. x.; Mayo on the Rectum, p. 182; and Rushe on the Rectum, New York, 1837.

ragments; and on examination the stricture may in readily felt. Irritation of the bladder and uterus, ps in the leg, with headache and dyspepsia, are al symptoms. If this affection be unrelieved, it f the rectum above the stricture, with a consequent he symptoms, and death from irritation.

e remedies are aperients and injections so as to pro- ritating stools, and the bougie. A bougie, capable h moderate facility through the stricture, should be three or four days, and be allowed to remain fifteen ; and its size should be gradually increased when a of being passed. An improved bougie is one in- tridge, made of a short cylinder of smooth metal, ender handle, so that the sphincter is not painfully od uses a bougie with a thick end and a slender stem, rve, to follow the normal sweep of the bowel and to direction to the point of the instrument which the per part. (See fig.) When the stricture is placed high,



ch lessens the danger of perforating the coats of the tricture. The curved bougie is introduced with the irected backward as far as the lower third. It is ned forward as in the "tour de maître" with the ents of every sort introduced into the rectum should e utmost gentleness. Nothing is gained by forcing ugh a stricture. The cure is to be effected by the e stimulus of pressure, so as to excite absorption, not al dilatation. There are numerous fatal instances on e bowel has been torn by bougies, and by that most thsome instrument, the common clyster syringe, in less or ignorant people. For the administration of should be only an inch and a half in length, with a remity. Or if in cases of stricture, or of obstinate eat accumulation of fæces, or of incarcerated hernia, ntroduce a tube further, it should be quite flexible omach-pump. But the natural sharp fold at the tum with the sigmoid flexure, and the fact shown by bowel not unfrequently makes a horizontal curve to escending into the pelvis, render the introduction of sigmoid flexure a very blind, hazardous proceeding, t often to be justified. Moreover the surgeon must st he fall by inadvertence into another error. That not pronounce his patient to have a stricture merely

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because the point of the bougie catches in the folds of the mucous membrane, or is obstructed by the promontory of the sacrum.

XVI. POLYPUS of the rectum, a rare disease; must be removed by ligature, or by knife, or the écraseur.

XVII. CANCER of the rectum is usually of the scirrhous variety, and situated at first about two or three inches above the anus. It may either commence as a distinct tumour, or as an infiltration of some part of the walls of the bowel. The earliest symptoms are uneasiness in the rectum, with a sense as if some fæcal matter had lodged there; aching and pain in the back, hips, and thighs, and irritation of the bladder. As the disease advances, the bowel becomes more or less obstructed; there is frequent discharge of a fetid muco-purulent matter streaked with blood; and there is a most obstinate constipation, attended with enormous swelling of the abdomen, and sometimes with all the symptoms of strangulated hernia; but this may alternate with the most profuse and exhausting diarrhœa. Abscesses about the rectum, opening perhaps into the bladder or vagina, aggravate the patient's misery, and death ensues from exhaustion, or from peritonitis, or perhaps from rupture of the distended bowels. This disease is to be distinguished by examination with the finger, or with the speculum; which will detect hardening and ulceration, or perhaps fungating tumours blocking up the gut.*

Treatment.—The first object is, to keep up the action of the bowels by enemata of warm water, and by the mildest laxatives: and to allay irritation by occasionally leeching the sacrum; by belladonna and opiate plasters; or occasional enemata or suppositories of opium, or large doses of henbane or conium; and by the tepid hip-bath. Sir B. Brodie recommends injections of linseed oil, either pure or mixed with lime-water, and balsam of copaiba with alkalies internally. When the obstruction threatens to become considerable, it will be expedient to use bougies, very gently, of the softest material, and not more frequently than is absolutely necessary. When these fail, it may be expedient, as a temporary resource, to cut through, or to excise some portion of the obstructing growth, or even to force the finger, or a flexible tube, through it, if possible with safety: some surgeons have even extirpated the lower extremity of the rectum; but all these operations can only be regarded in the light of palliatives. As a last resource, an artificial anus may be formed by Amussat's operation.†

For cancerous and epithelial diseases of the verge of the anus, and their treatment, by operation or otherwise, we may refer to the works of Lebert, Curling, and Lisfranc.

XVIII. PRURITUS ANI, a very violent itching of the anus, is a very

* In a case related to the author by Mr. Mayo, of Winchester, ulceration of the anus, of the worst syphilitic character, laid open the peritonæum between the rectum and vagina: a portion of omentum protruded; it was imperfectly replaced, as it was supposed, naturally enough, to be a prolapse of the rectum, and the patient died with symptoms of strangulation.

† Walshe, op. cit., p. 297. Cæsar Hawkins, Med. Chir. Trans., vol. xxxv.

troublesome affection. It may be complicated with an excoriated or fissured state of the surrounding skin (*rhagades*). The best plan is, to keep the bowels open with sulphur, seidlitz powders, or castor-oil, with occasional doses of blue pill; to put the stomach into proper order; to bathe the part very frequently with water as hot as can be borne; and to apply some stimulating or astringent substance, such as nitrate of silver, weak solution of corrosive sublimate, the citrine or creosote ointment, or lemon-juice. Thread-worms should be got rid of by enema of strong infusions of quassia. The liq. arsenici chloridi, F. 97, may be tried in an obstinate case.

Chloroform may be used mixed with lard (℥j. ad ℥j.), as an ointment, or, as Curling suggests, a few drops may be put into a wine-glass which may be held to the anus to act by its vapour.

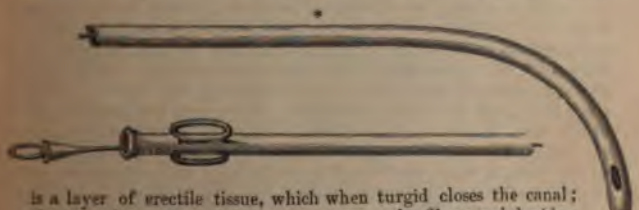
CHAPTER XX.

DISEASES OF THE URINARY ORGANS.

SECTION I.—RETENTION OF URINE FROM SPASMODIC STRICTURE.

I. RETENTION OF URINE.—This term signifies want of power to pass the urine from the bladder. It therefore includes the idea that there is urine to pass; and must be carefully distinguished both in theory and in practice from the *suppression* of urine, in which no urine is passed because none is secreted.

II. The urethra is a canal surrounded by various structures, whose actions are capable of hindering the flow of urine through it. There



is a layer of erectile tissue, which when turgid closes the canal; there is a layer of unstriped or organic muscular fibre; and, besides,

* Henry Thompson, F.R.C.S., &c., Pathology and Treatment of Stricture, being the Jacksonian Prize Essay, &c., Lond., 2nd edit., 1858. The cut shows a catheter, recommended by Mr. Thompson, and modelled according to the length and direction of the urethra. It is divided to suit the size of the page, and is exactly one-half of the real size. The axis of the point forms a little more than a right angle to that of the shaft.

at certain points there are voluntary muscles,—the muscles of Wilson and Guthrie, the levator ani, and accelerator urinæ.

The layer of organic muscle, the existence of which was inferred by Hunter, and demonstrated by Kölliker, has been more minutely investigated by Mr. Jabez Hogg and Mr. Hancock. According to the last-named gentleman, it appears that the urethra is invested by a double layer of organic or unstriped muscular fibre; one layer immediately surrounding the canal, the other external to the prostate and the *corpus spongiosum* urethræ; which muscular coats are continuous with those of the bladder. Hence not only can the canal be closed by spasm of the voluntary fibres which are in relation with its membranous portion, but any part of the canal may be closed by the layer of involuntary fibres. Moreover, it is well to bear in mind that violent voluntary efforts, as in straining to empty the bladder, tend to close the urethra by the action of the levator ani.†

The length of the urethra, according to Mr. H. Thompson, is about 8½ inches; its circumference unstretched ·5 inch at the meatus, ·7 inch in the bulbous portion; both dimensions capable of being stretched. Its lowest point in the erect posture is just anterior to the anterior layer of deep perineal fascia; its curved portion ·3 of a circle 3·25 inches in diameter; but that this curve is sharper in thin persons than in the stout. In children, the greater elevation of the bladder in the pelvis produces a greater curve in the urethra.

Varieties.—Retention of urine may arise from causes functional or organic. The *functional* causes may be, 1, want of power in the muscular coat of the bladder and urethra; 2, spasm of the urethra, mixed in some cases with some amount of inflammatory swelling. The *organic* causes include permanent stricture, that is to say, obstruction of the canal by organic disease and contraction;—cicatrices, the blocking up of the tube by stones or other foreign bodies coming down from the bladder, or introduced from without;—or by the presence of abscesses, or cancerous or other tumours;—or of fractured and displaced bones external to the urethra; or by disease of the prostate gland.

In the present section we shall speak of that form of retention of urine which arises from *spasm of the urethra*.

* A very useful syphon, which can be fixed on to the end of the catheter for the more convenient flow of the urine.

† Anatomy and Physiology of the Male Urethra, by Henry Hancock, F.R.C.S. Lond. 1852; Investigations of the Anatomy of the Urethra, &c., by Jabez Hogg. Pathological Trans., 1855.

III. SPASMODIC STRICTURE generally affects persons who are already labouring under some slight degree of permanent stricture, or whose urethra has been rendered irritable by repeated attacks of gonorrhœa, or by a diseased condition of the urine; these, therefore, are the *predisposing causes*. The usual *exciting causes* are, exposure to cold and wet, and indulgence in liquor, which disorders the stomach, and renders the urine unusually irritating. Hence, an attack of spasmodic stricture generally comes on at night. It may also be caused by cantharides, whether taken by the mouth, or absorbed from blisters applied to the skin. Like irritation of the bladder, it may be a symptom of gout. It may likewise be caused by sexual excitement and by piles and other sources of irritation of the rectum or bowels.

Symptoms.—The patient finds himself unable to pass his water, although he has a great desire, and makes repeated straining efforts to do so. The bladder soon becomes distended, and can be felt as a tense, round tumour above the pubes; and unless relief is given, the countenance becomes anxious, the pulse quick, and the skin hot. The straining efforts at micturition also become more frequent and violent, and the distress and restlessness are extreme. In this way the patient may, perhaps, go on for many days; a little urine passing occasionally when the spasm is less urgent, but the bladder still remaining loaded, till relieved by treatment. If not relieved, and if the urethra were previously diseased, either the bladder may burst into the peritonæum; or, as more frequently happens, the urethra behind the stricture (which, of course, becomes dilated and weakened under the pressure of the urine impelled by the whole force of the abdominal muscles) bursts into the perinæum, and give rise to *extravasation of urine*, as will be described in the third section.

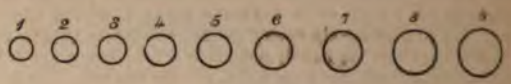
The *inflammatory stricture*, in which great pain and tenderness of the perinæum, and fever, are combined with spasm, is generally caused by abuse of injections, or by exposure and intemperance during acute gonorrhœa. The treatment of this and of the spasmodic variety must be the same.

Treatment.—The surgeon's proceedings must be regulated by the duration of the retention, and the amount of distension of the bladder, and by the previous history of the patient, as to the time during which the urinary organs have been diseased, and as to the exciting cause of the retention.

If the symptoms are not extreme, if they have been brought on by cold or conviviality, and there is no history of old stricture, a hot bath and continued fomentations, with a full dose of opium, and followed by castor-oil, or F. 38, will often relieve the patient. In cases in which there is no need of an aperient, a full dose of opium or Dover's powder, or an opiate enema or suppository, or a whiff of chloroform will suffice; for it is the great object to stop all violent voluntary efforts, and when they are discontinued the bladder will often empty itself easily. In inflammatory cases it may be requisite to leech or cup from the perinæum, or even to bleed, or give antimony; and large draughts of

soda water, with a teaspoonful of the bicarbonate added, and other alkaline liquids, are also often of great service in cases of no great urgency, arising from errors in diet. The muriated tincture of iron, in doses of ♏x. every ten minutes, is an empirical remedy, which the writer has often seen used. No one pretends to explain its *modus operandi;* and as it is seldom or ever given without the warm bath or other means, it is difficult to say what amount of benefit is really due to it.

But if these means do not succeed, a catheter must be introduced; or if the distension of the bladder be very great, it should be done at once, the patient being narcotized by chloroform. A silver catheter, of good size (8 or 9), may first be introduced. (This cut shows the sizes



of catheters and bougies adopted by Savigny and by most other makers, No. 1 being ·125 and No. 9, ·25 inch in diameter.) The surgeon should well warm and oil it, and pass it through the palm of his hand, so that he may make sure that it is smooth and fit for use. The patient may either lie down flat, or stand with his back against a wall. The surgeon, holding the catheter in his right hand, raises the penis with his left, and introduces the instrument, with its concavity towards the left groin. Then he gradually raises it till it is perpendicular with the abdomen; and then the instrument ought to pass under the pubes into the bladder, whilst the handle comes down to a horizontal position. The instrument should be held lightly, and let make its own way, so to say, along the passage. The surgeon, if necessary, may draw the penis well forwards on it, so as to stretch the urethra, and prevent the instrument from becoming entangled. He should make the point slide along the upper rather than the lower surface of the urethra. On meeting with an obstruction, he should press against it, but very gently; and by delicate manipulation for five or ten minutes, the stricture will in most cases be made to yield. The oiled forefinger of the left hand introduced into the rectum is a most useful help. Some surgeons prefer to pass the catheter without any stretching of the urethra, using one hand only, and holding the catheter with the concavity at first turned *downward* till the bulb is reached; and then turning it with a sweep in front of the left groin till the point turns upwards. This turn is called by the French the "tour de maître." If the penis be overstretched, the effect is certainly to narrow the diameter of the urethra, and to retard the catheter. On the upper wall of the urethra, about an inch and a half from the orifice, is a follicle, "lacuna magna," rather larger than the rest of the "glands of Littré," in which the point of a catheter may be caught.

If the silver catheter does not pass, the surgeon may try a gum

catheter that has been kept for some time on a wire, so that it keeps its curve when the wire is drawn out.

Instead of oiling the catheter, Mr. H. Thompson carefully fills the urethra with pure olive oil by means of a glass syringe, forcing it down to and through the stricture, and retaining it by the finger and thumb at the orifice till the catheter is introduced. Mr. Thompson says that the instrument passes with less pain by this means.*

Whenever spasmodic stricture occurs frequently or periodically, the surgeon should examine most carefully into those conditions of the health generally, and of the urine particularly, which give rise to it; and should resort to the catheter as sparingly as possible, unless there is some organic stricture requiring it. When there is great depression or debility, tonics; when periodicity of attack, quina; when an overloaded state of the bowels, aperients; and, when the urine is irritating, the measures detailed in the eighth section of this chapter should be resorted to.

Puncture of the bladder.—If none of these means succeed, and the bladder has become exceedingly distended, an operation will be necessary to relieve it, and save the patient's life. Although, we must observe, that this is never necessary from mere spasm, unless there is also extensive and old-standing disease of the urethra or prostate. The time at which it must be done must be decided by the surgeon's judgment; sometimes, as Sir B. Brodie observes, it is necessary within thirty-six hours, sometimes not for three or four days. The operations may be—

1. *Forcing a passage;* that is to say, pushing the catheter onwards through the obstruction into the bladder, as nearly as possible in the course of the natural passage. This is not applicable to stricture; but in cases in which the obstruction is in the prostate, and should only be attempted by one who is an expert manipulator, and thoroughly acquainted with anatomy.

2. *Incision of the urethra in the perinæum*, with or without division of the stricture. This, with the cases to which it is applicable, is described in the next section.

3. *Puncture of the bladder by the rectum* is performed by placing the patient on his hands and knees, or placing him on his back with his knees drawn up, and bringing him close to the edge of the bed, introducing the right forefinger into the anus, and a long curved trocar and canula by its side, then feeling for, and making sure of, the distended bladder just behind the prostate, and exactly in the middle line, and plunging the trocar into it—leaving the canula for four-and-twenty hours. The rectum should be first of all cleared by enema. The point of the trocar should be withdrawn slightly within the canula as it is being introduced into the anus, so that it may do no mischief.

This operation has been strongly recommended by Mr. Cock,† who has had great experience of its utility.

* On Stricture, p. 179, 2nd edit.

† Cock, Med. Chir. Trans., vol. xxxv.

4. *Puncture of the bladder above the pubes.*—This is performed by making a small incision through the linea alba just above the pubes,

and then thrusting a long trocar and canula downwards and backwards into the bladder, where it is not covered by the peritoneum. In performing this operation care should be taken that the point of the instrument does not glide between the bladder and pubis. The canula must be retained, and the patient be kept on his back to prevent extravasation; and no time should be lost in restoring the natural passage.

SECTION II.—PERMANENT STRICTURE.

PERMANENT STRICTURE signifies a contraction of the urethra, caused usually by inflammation, infiltration of plastic material, and subsequent shrinking of this material and of the canal, and gristly degeneration of the tissues around the canal. But Mr. Hancock has found, contrary to the general opinion, that lymph may be effused on the free surface of the mucous membrane, and then be developed into imperfect fibrous tissue, partially blocking up the canal. In some cases a small portion of the mucous membrane, perhaps only a line or two in extent, is found thickened and deprived of its natural elasticity; or perhaps contracted so as to form a sharp fold, as if it had been tied with a thread. But in old neglected cases, the canal with the *corpus spongiosum* around may be converted into a thick, gristly, cartilaginous mass several inches in extent. The most frequent *situation* of stricture is "in the substance of the bulbous portion of the canal, or a little anterior to it."*

* Henry Smith, F.R.C.S., quoted in Ranking, vol. x., 1843, with an account of examination of ninety-eight specimens. See the same author's work on Stricture, Lond. 1857, p. 29; Mr. Henry Thompson (*op. cit.*, 2nd ed., p. 61)

ics are repeated gonorrhœa, intemperance, and unhealthy
f the urine.

s.—In what may be called the *first stage*, the patient finds
its to make water oftener
and that he has more or
sensation in the peri-
doing so; he also notices
drops hang in the urethra,
from him after he has
. Then he observes that
of water is smaller than
forked, or scattered, or
that he requires a longer
greater effort than usual
Itching of the end of the
gleety discharge are fre-
mitants.

ease proceeds to its *second*
bladder becomes irritable,
e patient to rise in the
d his urine. He is liable
of spasms with complete
was described in the pre-
on. In one of these,
may ulcerate or burst,
o urinary abscess, or to
of urine, as will be de-
e next section. Rigors
aroxysms like ague fits
mmon. (See Section

he complaint is permitted to continue, the health suffers
nt irritation and want of sleep; the bladder and kidneys
; the complexion becomes wan; the appetite fails; the
ns of chills and flushes, of aching and weakness in the

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into three regions; and finds that out of two hundred and
two hundred and fifteen, or sixty-seven per cent., are situated
; which comprises an inch of the canal before, and three-
behind, the junction between the spongy and membranous
thra. "That part of the urethra," says Mr. Thompson,
uently affected with stricture, is the portion comprised in
the junction; that is, the posterior or bulbous part of the
The second region, comprising two and a half or three
first, was the seat of fifty-one strictures, or sixteen per
region, consisting of the anterior two and a half inches,
n per cent.
m a preparation in the King's College Museum, shows
and a stricture in the membanous portion just in front

back, and of great languor and depression of spirits; and the urine is constantly loaded with fetid mucus. After death, the urethra behind the stricture is found greatly dilated; the prostate, with its ducts dilated, and in a state of suppuration, or perhaps containing small circumscribed abscesses; the bladder sometimes dilated, but more frequently contracted, and enormously thickened; sometimes sacculated from a protrusion of its mucous coat between the fibres of the muscular; the ureters dilated, and converted into subsidiary receptacles for the urine, and the kidneys either greatly dilated or disorganized. An engraving illustrative of this will be found in the seventh section of the present chapter.

Treatment.—The remedies for stricture are twofold. The first, which should always receive the earliest and greatest attention, are such as tend to remove any disorder of the stomach, or of the general health, and any irritating quality of the urine, or inflammatory tendency about the parts concerned. It must be recollected, especially with people of education, that the *mind* has an important share in producing the *subjective* symptoms of stricture; and that gout will often produce pain and spasm in the perinæum, which can be charmed away by an alkaline purgative and colchicum; further, that every irritated and infiltrated tissue has a natural tendency to recovery, when the exciting causes are removed. If sexual indulgence, drink, dissipation, and gonorrhœa will produce chronic inflammation and tendency to stricture, it is equally true that chastity, temperance, rest, early hours, warm baths, purgatives, and alkaline remedies may undo the mischief. Hence it is a coarse and violent proceeding to introduce instruments into the urethra of a young man without pressing necessity, until a course of proper treatment has failed; and it may be a mortiferous proceeding in the case of an old man. Shiverings, fever, suppression of urine, and death may follow.

In every case then, admitting of delay, the surgeon should begin by calculating how much of the malady is removable by regimen and medicine, and should remove that first. Warm baths; opiate suppositories; belladonna smeared on the perinæum; and alkalies after meals may be of service. F. 38, 72, 77, 78, 79, 149, 181. (See *Gleet*, *Chronic Inflammation of the Bladder*, and *Urinary Deposits*.)

Then will be the time for the second class of remedies, consisting of *mechanical means*, such as 1. Dilatation by a bougie or sound: 2. Dilatation by means of expanding instruments: 3. By a retheter retained: 4. By the caustic bougie: 5. By incision from within: 6. By division from the perinæum. These we proceed to discuss in succession.

1. *The Bougie.*—The common bougie is, as its name implies, a wax candle, or cylindrical body composed of linen imbued with wax or plaster. It is flexible, becomes softened by heat, and is supposed to be capable of doing less harm than a metallic instrument, if mismanaged. Similar instruments (less safe) are made of gutta-percha and caoutchouc. But, as has been well said by Mr. H. Thompson, the surgeon who

knows what he is about will prefer to have an instrument that will obey his hand, and which is adapted to the normal direction of the passage. He will, therefore, prefer a metallic sound. But if the instrument is to be introduced by the patient himself, it may be flexible; and if the canal is tortuous from disease, and the natural direction lost, and the unnatural direction difficult to find, it may be convenient for the surgeon to use a flexible instrument, in the hope that it may find its own way into the bladder.

In the first place the surgeon desires to ascertain whether there is a stricture, and if so, where. For this purpose he takes a full-sized sound, *i. e.*, one that will enter the orifice easily, and fill it; and having warmed, oiled, and passed it through his hand to make sure of its polish, he introduces it in the manner directed for the introduction of a catheter. If it seems to meet with an obstruction, it should be drawn a little backwards, then most gently pressed onwards, to see if it will enter, and be grasped by it. If not, it may be exchanged for a smaller one, and gentle persevering trials be made—not too much at one time—to get the instrument fairly into the stricture. The surgeon should allow it to remain in for five or six minutes, by which time probably the patient will complain of sickness or faintness; and when he withdraws it, should make a note of the size. After three or more days—more or less according to the pain and irritation caused—the process may be repeated; and it must be gone on with at the same interval, with a gradual increase of the size of the instrument, till the canal is restored to its natural calibre. For some months afterwards it is expedient to pass a sound about once a fortnight. Chloroform may be given if there is great pain or difficulty.

Metallic bougies, or *sounds* made of silver, or steel plated, are always to be preferred to those of soft materials, 1st, if the stricture is old and very hard and gristly; 2ndly, in cases of very irritable urethræ, because their smooth polished surface is not so apt to cause spasm; 3rdly, in cases where a false passage has been formed, which these instruments, as they can be directed with greater precision, can be better made to avoid. They should be eight or nine inches long, not smaller than No. 4, their curved part need not be so long as that of a catheter, and they should be mounted on a firm wooden handle, and their point should be made to slide along the upper surface of the urethra when near the bulb, as it is below and at the sides that false passages generally exist, and are most easily made.

These instruments may also be used for the cure of old *impassable* strictures in the following way:—A sound of moderate size, about one-fifth or one-sixth of an inch in diameter, may be introduced once in three or four days, and be firmly pressed against the stricture for from five to fifteen minutes, taking care to keep its point against the upper part of the urethra. This will cause the anterior part of the stricture to relax a little; and if the process is repeated often enough it will at last clear the way to the bladder. Or a sound with a conical point may be introduced into the anterior part of the stricture, and kept

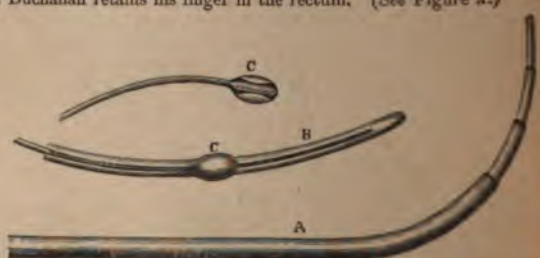
there for an hour or two at a time. This is often called the cure by *vital dilatation*.*

The *plaster bougie*, if used, must be slightly bent, and oiled. If its passage is resisted, gentle pressure may be tried, to see if it will enter the stricture. If it seem to pass, the operator should let go for a moment to see if it recoil; for it must be remarked that it may bend against the stricture without entering it, and may thus lacerate the canal.

†

If there is more than one stricture, a metallic sound with a bulbous point may be of use, because it will not be grasped by the first stricture after the bulb has passed.

2. *Urethra Dilators.*—The good effects of the bougie are owing to the stimulus of gentle pressure. But, in order to accelerate the cure, various plans have been proposed for effecting dilatation, with or without actual laceration of the stricture. First may be mentioned the *compound circular catheter*, used by Dr. Andrew Buchanan of Glasgow, 1831, and described in the Med. Gaz. for March 1841. It consists of three or more graduated silver tubes sliding one over the other, and the smallest sliding over a round-pointed probe. The external tubes acting as guides enable the inner ones readily to pass the strictured part, and when once a smaller tube has passed, it is safe and easy to slide in the others. In guiding this instrument along the membranous and prostatic portion, Dr. Buchanan retains his finger in the rectum. (*See* Figure A.)



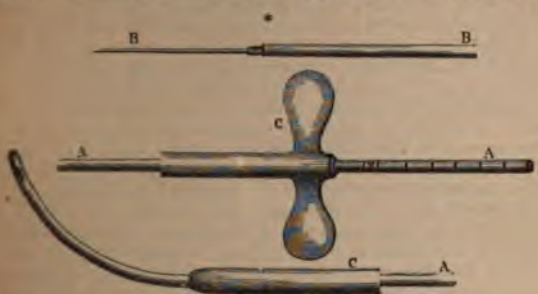
Dr. Sheppard, of Stonehouse, uses a very small catheter, B, grooved on one side: along this a metallic button, or *traveller*, C, can be pushed

* Vide Sir B. Brodie on the Urinary Organs, 3rd edit., 1842. Guthrie on the Urinary Organs, Lond. 1843.

† Sound with bulbous point. Natural size.

by means of a fine wire which lies in the groove. The travellers are of various sizes. The instrument is made by Weiss.

Mr. T. Wakley's instruments.—They consist of, firstly, a very small catheter, A, which is to be passed through the stricture into the bladder. Secondly, a slender steel rod, B, which is next to be passed



within the catheter and screwed into it. This rod and the catheter thus united form a *directing-rod*, over which other instruments are to be passed. Thirdly, there is a series of straight silver tubes, C, of graduated sizes; the smallest just one size larger than the directing-rod; the largest equal to a No. 10 bougie. Each of these tubes is constructed so as to glide accurately over the directing-rod; and thus, the latter being in the urethra, any stricture can be dilated to as great an extent as the surgeon thinks prudent at one sitting. Of course the size of our page prevents the artist from showing more than two ends of these instruments; the middle will readily be imagined by the reader.

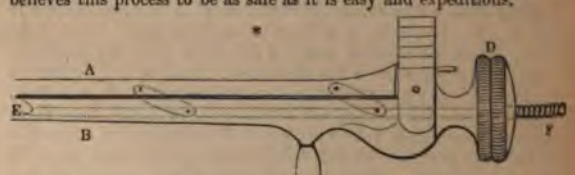
In the next place, *Mr. Holt's improvement of M Perreve's instrument*, may be mentioned. It consists of a staff, formed of two blades, A and B, joined at the smaller extremity, C, and capable of diverging by means of a screw, D, at the handle. Between them is a directing-

* Mr. Wakley's Dilator. See Lancet for 1851, vol. i., p. 122.

† Mr. Holt's Stricture Dilator. See Barnard Holt on the Stricture Dilator, Lond., 1852; and On Immediate Treatment of Stricture by means of the Stricture Dilator, Lond., 1863.

rod, E, and on this directing-rod, under cover of and between the two separate blades, a dilating-tube, F, can be passed down to and within the stricture after the staff in its undilated state has been passed.

Mr. Holt's instrument has been improved in the last few years. The directing-rod, E, is made hollow, with an opening at the back of the curve of the dilator, and is fitted with a stylet. Thus urine will flow through it so soon as it has reached the bladder, and this fact will be made clear. This was devised by Mr. Smyly, of the Meath Hospital. Mr. Holt begins by ascertaining the permeability of the canal, and the gauge of a sound that will fit the orifice of the urethra. A dilating tube of the same size is then chosen, and some screws in the handle (which do not appear in our figure) are then *set* at such a distance as to let the dilating tube pass, but not to allow the urethra to be stretched further. The instrument is then introduced closed. When the bladder is reached, the dilating tube is pushed home quickly so as to *split* and not merely *dilate* the stricture. The dilator is a little rotated to insure separation of the split, and is then withdrawn: a catheter introduced to draw off the water, and the patient sent to bed with directions to take every four hours two grains of quinine and ten minims of laudanum. A catheter should be introduced once a day for a week, and then occasionally, to keep the passage open. Mr. Holt believes this process to be as safe as it is easy and expeditious.



Mr. Coxeter has an instrument consisting, like the foregoing, of two blades, joined at the smaller extremity. The upper blade, A, is connected with a rod, E, which works within the lower blade, B, by several small bars riveted at each end, whose action is like those in the well-known instrument called the parallel ruler. By turning the nut D, the rod, E, which ends in the screw, F, is pushed forwards; thus the connecting bars cause the upper blade, A, to separate from the lower.

3. If a *small catheter is retained in the bladder* for two or three days, the passage suppurates and dilates remarkably; just as the lachrymal duct does from the presence of a style. This method of cure may be attempted when the stricture is very gristly and cartilaginous; or when the urethra is irregular, or has had a false passage made in it. The catheter should be of silver, and should be retained by means of two strings, which may be passed backwards between the thighs, and be fastened to a band round the waist. It should be removed in two or three days, and a larger catheter should

* Coxeter's Stricture Dilator.

be passed four-and-twenty hours afterwards, and should be introduced often enough subsequently to keep up the dilatation. But the continued presence of the catheter is liable to cause so great an amount of irritation that it cannot always be borne, even with the aid of opium.

4. The *caustic bougie* is a most powerful agent in deadening the sensibility of very irritable stricture, but is liable, if mismanaged, to produce inflammation, retention of urine, hæmorrhage, abscess, and any other conceivable mischief. Two kinds of caustic are used; the nitrate of silver and the caustic potass. The caustic potass is much used by Mr. Wade, who speaks highly of its effects.*

The *nitrate of silver* may be used by means of a small fragment inserted into the end of a bougie. There are, besides, instruments for cauterizing the urethra, especially its prostatic portion, such as the *porte caustique* of Lallemand; in which a stilette coated with the solid nitrate can be protruded: there is an instrument used by Henry Smith and others, in which the stilette is covered with sponge, dipped in a solution of the lunar caustic;—and, still better, a catheter, devised by Mr. Erichsen, for injecting a few drops of caustic solution into any part of the urethra that it may be desired to operate on.

5. *Puncturation*, or division of the stricture by means of the *lanceted stilette*,† invented by Mr. Stafford, or of Mr. Fergusson's *urethrotome*, may be resorted to in some cases of old stricture of small

extent, at the anterior part of the urethra, which resist dilatation. The lanceted stilette consists of a tube, A, straight or curved, which is

* Robert Wade on Stricture of the Urethra, 2nd edit., Lond., 1849. See also H. Smith on Stricture, p. 121. The observations in H. Thompson on Stricture, 2nd edit., p. 229, on the measured and observed effect of minute fractional parts of a grain of the potass, are well worth reading.

† Stafford on Stricture, Lond. 1829. Fergusson, Pract. Surg., 3rd edit., p. 190.

‡ Fergusson's urethrotome.

pushed down to the stricture, and from which a lancet, B, can be made to protrude by pressure on the head, C, so as to divide the contracted texture. The screw D regulates the extent to which the lancet protrudes; and a spring within the larger extremity of the instrument provides for the return of the lancet within its sheath. Mr. Ferguson's urethrotome consists of a very long director, under cover of which a very narrow blade can be introduced.

Another instrument consists of a sound of ordinary dimensions, ending in a narrow director. The latter is passed through the stricture, and then a lancet-blade can be thrust forwards, along a slit running through the length of the director. Thus the lancet cannot get out of the proper channel.

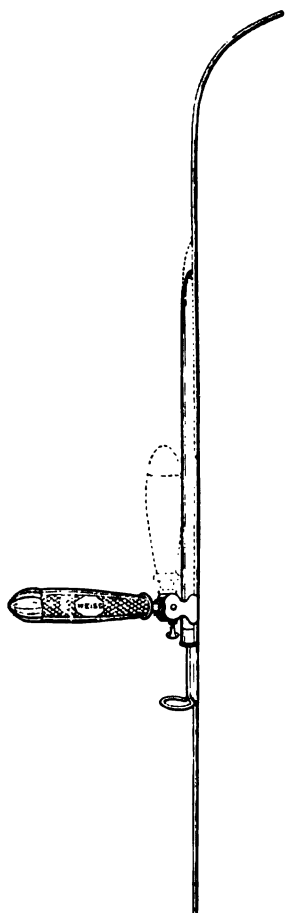
Wood's urethrotome dilator combines the properties of a dilator of the urethra with that of scarifying the stricture while stretched. The scarifications are limited in extent, and only made in the callous tissue of the stricture, which alone is put upon the stretch by the dilator. Being confined to the indurated tissue, there is less likelihood of hæmorrhage, pyæmia, or urinary extravasation, than when a free internal incision is made into the areolar and very vascular substance of the corpus spongiosum. Mr. Wood believes that it produces a less irregular cicatrix than the mere splitting, which might cause another stricture. By the application of a clean, straight, and limited incision, as in dividing a stricture of the rectum all round, this return in an aggravated form is less probable, and less force is required to accomplish dilatation, which is obtained in a slow and gradual manner. The instrument (see fig. p. 617) is composed of a grooved director of the size of a No. 1 catheter, which is first passed through the stricture into the bladder, as shown by a few drops of urine trickling along the groove. Over this is then passed a *dilator*, of the size of a No. 12 catheter, with an oval section of which the longest diameter is vertical. This terminates in a conical extremity provided with a slit below, which transmits a small *urethrotome* or cutting blade to the extent of a quarter of an inch, protruded by pressing upon a small thumbplate at the opposite end of the dilator tube. A stout handle projects obliquely at the end of the dilator, by which the operator obtains a firm and steady command over the instrument.

When the conical point of the dilator is felt to be fairly held by the stricture the blade is gently protruded first on one side and then on the other of the stricture until it is felt to yield gradually to the dilator pressed firmly onward at the same time.

Mr. Wood thinks this instrument safer and more under command than any other urethrotome, while it may, if desired, be used as a dilator only.

6. The operation of OPENING THE URETHRA FROM THE PERINÆUM is absolutely requisite in all cases of rupture of the urethra

extravasation of urine, and in cases of stricture complicated abscesses or false passage when no instrument can be passed; is expedient in cases of very icture with extensive urinary , when the health is giving nd other means fail of afford- lief. It is performed thus: patient is placed in the my position; a grooved staff ed through the stricture if le. If this be not possible, t be passed down to it. The refinger, introduced into the n, is to feel for the staff in ethra, and serve as a guide incisions. Then a straight ry is to be plunged in just the anus to the depth of an with its edge upwards, and to cut its way out upwards e middle line of the peri- . The end of the sound next be felt for and cut and the knife is then to be l backwards through the ure into the urethra beyond ich is always more or less l and prominent, especially patient is told to strain and pass urine. The stricture be thoroughly divided, and uses laid open. A catheter l then be passed into the r, and be retained there for y-four or forty-eight hours. he operator desires merely ieve the bladder, and does ink it prudent, from the pa- condition, to make the more ive incisions through the ure which we have just de- l, he may, after the first in- keeping the back of the knife rectum, cut into the mem- us part of the urethra behind ricture, and so get a female er into the bladder, reserving ricture for future treatment.



7. *Perinæal Section.*—Professor Syme has recommended this operation, not merely for cases in which incision is commonly considered necessary, that is, for cases of impervious and complicated stricture; but for others, in which, *although an instrument can be passed*, the stricture is excessively irritable, and resists the common treatment by dilatation, or contracts again perpetually, and is wearing out the patient's health by pain, rigors, and other signs of irritation, and in which the patient's state of health is such as to render an operation on these parts safe, and the residue of his life worth enjoying. The patient having been put under the influence of chloroform, and held in the lithotomy position at the edge of a bed, "a grooved director slightly

curved, and small enough to pass readily through the stricture, is introduced and confided to one of the assistants. The surgeon, sitting or kneeling on one knee, now makes an incision in the middle line of the perinæum or penis, wherever the stricture is seated."* It should be about an inch and a half long, and extend through the skin and textures external to the urethra. The operator then taking the handle of the director in his left, and the knife, which should be a small straight bistoury, in his right hand, feels, with his forefinger guarding the blade, for the director, pushes the point into the groove behind the stricture, and runs the knife forward so as to divide the *whole* of the thickened texture at the contracted part of the canal. A full-sized catheter should be retained for twenty-four hours afterwards. The cases in which this operation is allowable are specified above. The amount of fatality attending it must be difficult to be estimated precisely: it will be less in private than in hospital practice, and in proportion as the patients are free from renal disease. Out of 219 cases collected by Mr. Thompson, only 15 deaths occurred within two or three months of the operation, and of these, 9 were hospital cases, which proved fatal by pyæmia. This is the greatest danger: hæmorrhage seems not to be so great a source of risk.†

8. Lastly, supposing a case of old complicated gristly stricture, with complete retention from inflammation or spasm, the surgeon must estimate whether it might not be safer on the whole to puncture the bladder by the rectum, and so to give a period of tranquillity to the diseased parts, than to run the risk of a large wound in imper-

* On Stricture of the Urethra, by James Syme, F.R.S.E., Edin., 1849.

† See the very fair and impartial summary of the value of this operation in Mr. H. Smith's work on Stricture, p. 252; also in Mr. Thompson's work, p. 302.

fectly vitalized tissues, in a constitution, perhaps, already almost worn out.

In whatever manner a stricture has been cured, the bougie should still be used at intervals, to prevent a fresh contraction.

SECTION III.—URINARY ABSCESS, EXTRAVASATION OF URINE, AND FISTULA IN PERINÆO.

I. URINARY ABSCESS is a frequent consequence of stricture. Either an abscess forms in the cellular tissue close to the urethra, and after a time opens into that canal; or, perhaps, one or two drops of urine escape into the cellular tissue, in consequence of ulceration of the urethra behind the stricture; and this small quantity of urine produces inflammation, so that an abscess forms, filled with dark-coloured putrid pus. This may make its way behind the pubes, or between the bladder and rectum; and may point above the pubes, in the groin, or even burrow into the fascia of the thigh. But its more usual course is to produce a tumour, pointing in the perinæum, forming between or in front of the layers of the triangular ligament.

Symptoms.—A patient with old stricture complains of rather more difficulty of micturition than usual, and of some amount of obscure swelling of the scrotum or perinæum, of an œdematous kind. There may be little or no pain, and little inflammation for the first twenty-four hours; after this the swelling increases; if in the scrotum rapidly; if in the perinæum it will be deep, hard, and painful, but not prominent. Shivering, hot skin, and dry tongue follow.

Treatment.—The abscess should be opened immediately, and the patient may soon be brought from the gates of death to comparative health. It will also be expedient to cut through the stricture as directed in the last section, and pass a catheter into the bladder.

II. RUPTURE OF THE URETHRA AND EXTRAVASATION OF URINE.—This is another consequence of old stricture, and it generally happens

* This cut exhibits the urethra laid open; a stricture at the commencement of the bulbous portion; and false passages, one of which leads into an abscess that surrounds the membranous portion.

in the following way:—A patient, who has long been labouring under difficulty of micturition, has a fit of spasmodic retention more obstinate than usual. He is repeatedly getting out of bed, and straining with all his might to pass his water. At last, during one violent effort, he plainly feels that something has given way; his painful sense of distension becomes immediately less, and he is very well pleased, and thinks himself better. And perhaps he is now able to make a little water by the natural passage, because the stricture generally relaxes, when, by any means whatever, it is relieved from the former pressure. But at the time when something seemed to yield, the urethra burst; the urine was forced by the whole power of the abdominal muscles into the cellular tissue of the scrotum, perinæum, and groins; the patient soon complains of a smarting or tingling about the anus and perinæum; the urine, which has become putrid and concentrated by long confinement in the bladder, speedily causes inflammation and sloughing; the skin over the infiltrated parts displays a reddish blush, which is soon succeeded by black spots of gangrene; low typhoid symptoms appear; the tongue is black, the pulse begins to falter, the skin is clammy; low muttering delirium and hiccup come on; and the patient soon departs this life, unless proper measures are taken for his relief. A black spot on the glans penis, indicating that the urine has penetrated the corpus spongiosum, is a very fatal sign.

Treatment.—A staff or catheter must be passed as far as possible, and it may sometimes be passed quite into the bladder, because, as was observed above, the stricture generally relaxes after the bladder is unloaded, be it how it may: the perinæum must be incised in the middle line, and at the same time free incisions must be made into any parts that are swelled or emphysematous, showing that they have been pervaded by the urine. The first points necessary for the patient's safety, viz., the relief of the bladder, and the escape of putrid pus and urine being thus provided for, the surgeon must use his own discretion as to meddling with the strictured part then, or reserving it till the patient has rallied a little.

The urethra may also be ruptured by blows or kicks on the perinæum, or by accidents that fracture the bones of the pelvis. The symptoms will be pretty evident. The patient will be unable to make water; or if he attempts it, the urine will be extravasated into the perinæum and scrotum. There will also be bleeding. The treatment consists in introducing a full-sized catheter into the bladder, and retaining it for twenty-four hours; and in incising the perinæum if urine has been extravasated.

III. FISTULA IN PERINÆO, or *Urinary Fistula*, signifies an opening from the perinæum into the urethra, through which the urine dribbles when the patient makes water. It is a frequent consequence of urinary abscess and extravasation.

Treatment.—The first and most essential measure is, to restore the urethra to a healthy state, and to dilate any strictures that may happen to exist, by the bougie. When this has been done, the fistula should

be stimulated to granulate by injections of arg. nit., or by passing a heated wire into it; and the external orifice should be occasionally touched with potass, so as not to allow it to heal before the whole track is closed—otherwise fresh abscesses will form. In extreme cases the urethra must be laid open, as before directed. For loss of substance, an incision may be made on either side, and the edges be vivified and brought together by suture.

Sometimes there is a *blind* fistula in perinæo; that is, a small narrow fistula, opening into the urethra, but not externally. It is occasionally inflamed and tender; and may be felt as a small tumour in the perinæum; perhaps the size of a horse-bean. It is attended with more or less discharge from the urethra. The treatment consists in laying the tumour open, and dilating any strictures that exist.

Sometimes a fistulous communication forms between the urethra and rectum. This may be known by air, and sometimes liquid fæcal matter passing through the urethra. It is to be treated by dilating the urethra, so that the urine may pass freely; and then a heated wire may be introduced into the fistula from the rectum, in order to close it by the adhesive inflammation.

SECTION IV.—OF SOME OTHER AFFECTIONS OF THE MALE URETHRA.

I. CONTRACTION OF THE URETHRA FOLLOWING INJURIES, such as blows on the perinæum, must be treated in the same way as permanent stricture. It usually results in the most intractable form of stricture.

II. CONTRACTION OF THE ORIFICE of the urethra may be a congenital affection, or may be caused by the cicatrization of ulcers. It must be counteracted by the daily passage of a short bougie, otherwise it may produce all the evil consequences of stricture further back. If the contraction is very great, and causes retention of urine, one of Anel's probes, a common probe, and a director may be introduced in succession, and then, when the bladder is emptied, the orifice must be dilated by a slight incision downwards.

III. FALSE PASSAGE.—This may be produced by using too small a sound, and pushing it out of the urethra, or by the misuse of caustic bougies. There is nothing to be done for the false passage; but the stricture, which was the origin of it, must be treated either with the metallic sound, or by keeping in a small catheter. When the surgeon suspects that he has pushed an instrument out of the right passage, he ought to leave the urethra untouched for at least a week, when the false passage will frequently close and become obliterated. This usually takes place if a proper passage be kept open for the urine. Injudicious meddling with a small catheter will, however, cause the false passage to remain pervious for a long time.

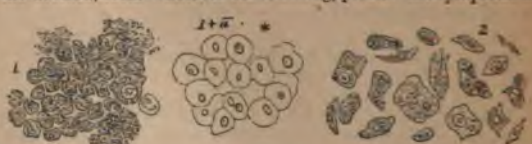
IV. HÆMORRHAGE FROM THE URETHRA may be caused by the rude introduction of bougies, or by injuries from without, or by the

separation of a slough formed by the caustic bougie; or, lastly, by a rupture of blood-vessels during acute chordee. If the application of cold does not check it, pressure may be tried. A flat piece of cork should be pressed by the patient against the perinæum far back, and be gradually moved forward, till it lights on the right spot, and the dripping of blood ceases. Gallic acid may be of service, or a solution of tannin in iced water used as an injection.

V. SOLID TUMOURS in the course of the urethra, composed of indurated follicles, torment the patient by keeping up a perpetual gleet and chordee. The mercurial ointment with camphor externally; and the passing of a bougie; or keeping a small catheter in the bladder for a few days at a time—are the chief remedies.

VI. TUMOURS WITHIN THE URETHRA, formerly called *Caruncles*, consist either of vascular excrescences near the orifice, which may be snipped off or cauterized; or of small polypi growing from the prostatic or membranous portion. Both are rare.

VII. ACUTE AND CHRONIC INFLAMMATION of the mucous lining of the urethra, from whatever cause arising, present the symptoms and



consequences, and require the treatment, of the gonorrhœa and gleet which arise from contagion. The author has found epithelium only in discharges from the male urethra, which yet caused great irritation to the female after connexion.

VIII. FOREIGN BODIES in the urethra may consist of calculi, pieces

* 1. Discharge from gonorrhœa, all but cured. 1+a. The same, with acetic acid. 2. Discharge in a case of obstinate idiopathic gleet; patient had been long married; wife had vaginitis with discharge; infant, ophthalmia neonatorum.

† The Urethral Forceps consists of two blades, capable of being expanded by being pushed through the canula A, and of being closed if the canula is pushed forwards above them; D, a screw, regulates the distance to which they can be expanded.

other source of irritation. The *symptoms* are, great weight, pain, and throbbing at the neck of the bladder, and tenderness of the perinæum; the gland feels swelled and tender on examination by the rectum, and there are frequent, violent, and exceedingly painful efforts to make water: as the disease subsides, a greyish viscid muco-purulent matter is voided by the urine.

Treatment.—Rest in bed, cupping or leeches to the perinæum, or general bleeding if the patient is strong, hot baths, poultices, and fomentations: and enemata of starch ℥ij., laudanum ℥ss. every night. If the urine cannot be passed without it, a very small gum catheter may be introduced; but it should be avoided if possible.

II. CHRONIC INFLAMMATION, with enlargement from interstitial deposit, may be a sequel of the acute; and should be treated by baths, small doses of mercury, alkalies, and iodide of potassium.

III. ABSCESS of the prostate is an occasional, though rare, consequence of tubercular deposit in scrofulous subjects. It is more commonly an acute affection, and may be suspected if rigors, and obscure swelling in the perinæum, with an evident and elastic enlargement felt by the finger in the rectum, with great tenderness on pressure, follow the symptoms of acute inflammation. The dorsal vein of the penis is often distended; there is some œdema of the prepuce, and semi-erection of the penis from pressure. In any such case, the swelling should at once be freely punctured through the rectum with a bistoury. If left to itself, the abscess may burst into the rectum or the urethra, which latter circumstance will be indicated by a sudden discharge of pus with the urine, and a stinging pain accompanying the discharge of the last few drops. If the signs of its having opened into the urethra are present, no opening should be made through the rectum or perinæum, lest a urinary fistula ensue. Perhaps there may be hæmorrhage. If the case is chronic and the habit scrofulous, quinine and tonics, and small doses of cubebs, to act as a gentle stimulant on the parts, will be of service.

IV. CHRONIC ENLARGEMENT, or HYPERTROPHY.—"The prostate," says Mr. Ellis, "is essentially a muscular body, consisting of circular or orbicular involuntary fibres, with one large central hole or the passage of the urethra, and another smaller oblique opening, directed upwards below the former for the transmission of the common ejaculatory seminal ducts to the central urinary canal. . . Its circular fibres are directly continuous behind, without any separation, with the circular fibres of the bladder." The prostate is thus essentially a circular involuntary sphincter to the neck of the bladder, and expeller of the seminal fluid; but although it contains many mucous glands and follicles, intermixed with the muscular fibres, it is by no means entitled to the name *gland*. It contains, further, a small vesicle or utricle, at the mouth of which the ejaculatory ducts open, and which is believed to be the male homologue of the female uterus.

The affection we now treat of is peculiar to advanced life, and consists in an hypertrophy or enlargement of the natural muscular struc-

ture, and incidentally of the glandular. "In youth," says Mr. Thompson, "the organ becomes enlarged by interstitial plastic effusion, the result of inflammatory action. In age there is an unnatural development of the prostatic tissue itself."

The increase may be but slightly above the ordinary chesnut size of the gland, or it may render it as large as a man's fist, or larger. It may affect the whole organ, especially the lateral lobes, pretty uniformly; in which case the prostatic portion of the urethra is greatly lengthened; or it may affect one side more than the other, in which

* †

case the canal will be twisted; or it may affect the posterior median portion, which lies between the ejaculatory ducts, enlarging it into what is commonly called the *middle* or *third lobe;* a lobe which, according to Mr. Thompson, is purely the result of unnatural enlargement and does not exist in health. The consequence of this is, that there is a projection at the very orifice of the urethra, causing a most serious impediment to the issue of the urine. The prostatic portion of the urethra, besides being lengthened, twisted, and obstructed, may be very much narrowed; or, on the contrary, may be expanded into a sort of pouch, which may communicate with cavities formed by the dilated ducts of the gland, and contain calculous matter. Hypertrophy and derangement of the muscular fibres at and near the *trigone*, may produce a transverse bar at the neck of the bladder.

* Enlarged prostate. † Cyst of the prostate from the King's College Collection.

The enlargement, further, may be due to an increase of the organ generally; or to the development of one or many masses of FIBROUS TUMOUR; exactly similar in structure to those concentric masses of muscular fibre which are developed in the womb, and are commonly known as *fibrous tumours*. One or more of these masses, involving more or less glandular tissue, may be developed alone, and may project as a pedunculated tumour; or may be contained within the prostate, capable of enucleation, and may constitute the whole disease; or may be combined with general hypertrophy.

The *symptoms* of this disease may be divided into those which the surgeon ascertains by physical examination, and those of which the patient himself makes complaint. On examination, by means of a well-oiled forefinger introduced into the empty rectum, the surgeon ascertains the existence of the tumour; and on using the catheter, finds an obstruction at the neck of the bladder. Most probably, too, after the patient has voided all the urine that he can, the catheter will relieve him of a further quantity.

The symptoms which the patient describes are slowness and difficulty in making water, sense of weight in the perinæum, and tenesmus; so that, as Coulson observes, he often believes he has internal piles. In the next place, the bladder becomes irritable, and the calls to make water are oftener than before. Then, as the patient cannot empty the organ completely, in consequence of the projection formed by the tumour, a portion of urine always remains behind, and decomposes, and becomes ammoniacal. Sometimes a fit of complete retention ensues, and it may be brought on by exposure to cold or excess in venery. Next the mucous coat of the bladder, irritated by the frequent strainings, and by the alkaline urine, inflames and secretes a viscid mucus. Finally the obstacle continuing to increase, the bladder is constantly distended, the urine perpetually dribbles away, the ureters become dilated, the kidney disorganised, the patient's little remaining strength is exhausted, and he dies. Abscess in the gland, or ulceration of that surface which projects into the bladder, sometimes adds to the patient's misery, and hastens his death.

The *causes* of this hypertrophy are as unknown as those of any other tumour. It generally commences, as Sir B. Brodie observes, about the time that the hair turns gray, and when earthy specks begin to be deposited in the coats of the arteries. Not, however, that all old men have enlarged prostates; on the contrary, as Mr. Thompson observes, the change is abnormal and exceptional. Out of forty-three specimens from men of 50 and upwards, he found two atrophied; nine enlarged slightly; and only five considerably, or to such a degree as to have given rise to symptoms during life. He believes that the change rarely begins before 55, or after 70.

Treatment.—This must be palliative. The patient should avoid irregular diet, fatigue, and exposure to cold. The bowels must be kept easy, so that there may be no straining at stool;—irritation of the bladder must be alleviated by the measures we shall speak of in the

rt section; and occasional fits of pain or congestion by leeching and t baths. The surgeon must take care that the bladder is regularly ptied, and if not he must introduce the catheter at intervals to get l of the residual urine. The catheter should be long; its curved rtion about a quarter of a circle whose diameter is 4·5 or 5 inches. e handle should be well depressed between the legs as the point is tering the bladder, in order that the point may ride over the projec- n. The finger also may be introduced into the rectum to guide it. small gum catheter which has been kept a long while on an iron wire the proper curve, may be useful. If the prostatic urethra be twisted one side, a very flexible elastic gum or india-rubber catheter of full e, ending in a tapering point with a small knob to it, will be found ry useful in finding its way through the devious passage into the dder. It should be passed with a twisting motion so as to give a ral course to the point. A silver catheter, with a very short abrupt rve, is recommended by Coulson.

In order to empty the bladder completely, it may be necessary to turn patient on his hands and knees. In any long-neglected case the ne may be drawn off in small quantities at a time, and the strength well supported with tonics, wine, and plenty of nutriment.

Radical remedies for producing absorption of the tumour, such as ercury, the iodide and bromide of potassium, and certain mechanical angements, have been proposed. But in the present state of know- e, it is not desirable to use any such remedy in any way that shall rfere with the patient's health and comfort.

. Complete Retention of Urine from enlargement of the tate. In this case, if there are inflammatory symptoms, cupping the perinæum, the hot bath, and opium are indicated. The ter should be passed if possible. If, however, the catheter cannot ssed by the natural route, the surgeon, guiding it with his left ger in the rectum, may thrust it through the projecting part of nd into the bladder, or he may use a lanceted stilette. But if nnot be done, the last resource is puncture of the bladder; by the , if possible; if not, above the pubes.

Calculi of the prostate are composed, according to Dr. G. Bird, r calculous concretions on mucous membranes, of phosphate of ed with triple phosphate, and may be deposited either in the rethral canal of an enlarged prostate, or in the ducts and cells

l, or in both. The most remarkable instance of prostatic record is related by Dr. Herbert Barker, of Bedford, to

whose kindness the writer is indebted for the engraving of it in the preceding page. The entire calculus is nearly 4¾ inches in length, and, at its broadest extremity, 4⅜ inches in circumference, and weighs 1681 grains. It is composed of twenty-nine separate portions, slightly adhering by conchoidal surfaces, no doubt originally deposited in separate cells of the prostate, and the whole agglomerated into one mass by the absorption of the intervening tissue.*

The *symptoms* of these concretions are, at first, irritation of the neck of the bladder, and difficulty of micturition, as in other cases of enlarged prostate; the calculi may also be probably felt with the sound or by the finger in the rectum. In some cases it may suffice to keep the urethra well dilated, so as to favour spontaneous escape; or it may be possible to remove one or more with the urethral forceps; but should they cause great irritation, abscess, or retention of urine, it will be necessary to cut down on them from the perinæum, and remove them, as was successfully done by Dr. Barker.

VII. CANCER of the prostate is very rare. In one or two cases of hard cancer which occurred in Sir B. Brodie's practice, the gland was enlarged, of a stony hardness; there was great pain in the groins and perinæum, irritability of the bladder, and cancerous cachexia. Soft cancer is equally rare. The symptoms are nearly the same as those of cancer of the bladder.†

SECTION VI.—DISEASES OF THE BLADDER.

I. IRRITABLE BLADDER.—Many cases described under this title are cases of gout or of inflammation. Simple irritability, that is, a frequent inclination to pass the urine with or without spasm; but without inflammation or organic disease, may be caused, 1. By an irritating state of the urine; the qualities of which, and the presence otherwise of oxalate of lime, triple phosphate, and albumen, should be ascertained; 2. It may be the effect of mere nervousness, which is not uncommon in elderly people, or of mental agitation; 3. It may be caused by irritation of the rectum, womb, or other adjacent organ, notably in children by irritation of ascarides; 4. By general debility; 5. By exposure to cold. The surgeon should examine into cause. Soothing medicines, such as belladonna, F. 149, may be of use.

II. NOCTURNAL INCONTINENCE.—Involuntary flow of urine during the night is common enough in delicate children; but the surgeon may be consulted on account of its continuing to an age at which such an infirmity becomes very troublesome and degrading. Any such case should be carefully studied under these heads. 1st. It should be ascertained whether the urine is irritating in quality or excessive in quantity; which it very frequently is. Thus, it will often be found, that the malady is aggravated when the bowels are confined, or the diet unwholesome, or saccharine drinks used too freely, or when there is

* Trans. of Provincial Medical Association, N.S., vol. iii.
† For cases, see Coulson, op. cit.; Stafford M. C. T., xvii.

been too much fatigue; all which circumstances must be avoided. (See Section 8.) 2nd. If there is nothing wrong in the urine, the condition of the bladder must be attended to; blisters to the sacrum; tonics, or very small doses of nux vomica, may be of service. 3rd. The habit must be attacked; the patient may be awakened at a certain hour, so that he may void his urine of his own accord: sometimes touching the orifice of the urethra with nitrate of silver, so that the flow of urine may cause severe smarting, is worth trying. The habit not unfrequently results from the patient lying upon his back habitually when asleep, so that the urine is kept constantly upon the over-sensitive surface of the trigone. By turning him on the side or face, this may be avoided. Small doses of tincture of cantharides are also recommended; but the writer has more than once seen the malady increased tenfold by the use of this drug in cases in which irritating and too copious urine was the source of the mischief.

III. Paralysis of the bladder may occur under many circumstances. It may be caused by injury or disease of the head or spine; it is often present in typhus fever—it may be caused for a time by any severe injury, especially of the legs—it generally remains for a few days after the bladder has been long distended, whether from prostatic disease or stricture—and it sometimes occurs suddenly to nervous sedentary people, who, if they let their bladder get filled beyond a certain point, find that they cannot empty it. The symptoms of it are, either retention of urine, *i.e.*, that the patient cannot make water at all; or else incontinence of urine, *i.e.*, that the water dribbles away without his being able to hold it, from over-distension of the bladder overcoming the elastic contractility of the neck of the bladder. The diagnosis of retention through palsy, from retention through stricture, is easy. The retention from palsy comes on suddenly, and there is no obstacle to the introduction of a catheter. Yet palsy of the bladder may be combined with spasmodic stricture.

Treatment.—The catheter, if required; in pure palsy, the muriated tincture of iron: cubebs, buchu, strychnine. Benefit has been obtained by passing shocks of electricity from the pubes to the sacrum. F. 21, 180, &c.

Sloughing of the entire mucous lining, with a layer of the muscular coat, has been recorded by Mr. Spencer Wells, Mr. Barnes, and Dr. Martyn. In each case there was retention of urine after severe labour; in Dr. Martyn's the slough came away as an entire cast of the inner surface a month after the labour.*

IV. Incontinence and Dribbling of Urine.—This is a symptom that requires particular notice; because in nine cases out of ten it happens, not because the patient cannot *hold* his water, but because he cannot *pass* it,—either from stricture or enlarged prostate, or palsy of the bladder. For it must be noticed, that in either of these cases, so soon as the bladder becomes full, a little urine begins to dribble away through the urethra—and besides the patient may perhaps be able to squeeze out a little by straining with his abdominal muscles, and may

* Obstetrical Trans., vol. v. p. 188.

believe his bladder to be empty, although all the while it is enormously distended. No surgeon will fail to put his hand on the pubes when he sees the urine dribbling away. The obvious remedy is the catheter.

V. HYSTERICAL RETENTION OF URINE.—There is one form of palsy of the bladder which is not unfrequent in hysterical women, and which consists in a deficiency of will rather than of power. They are not unable to empty the bladder if they try—but they are unable to try. These cases must be treated with purgatives, and fetid medicines, both internally and as enemata, F. 102. If the catheter is not employed, the patient will generally begin to make water so soon as she suffers much from distension.

VI. ACUTE INFLAMMATION of the bladder (*cystitis*) in young persons is most frequently a consequence of neglected or ill-treated gonorrhœa; in older persons it may arise from gout; or it may be an aggravation of persistent chronic inflammation from stone or stricture. The *symptoms* are pain, referred to the perinæum and sacrum, tenderness of the lower part of the abdomen, micturition exceedingly frequent, attended with great straining, and followed by an aggravation of the pain, a mucous or muco-purulent sediment in the urine, and fever. (See p. 634.)

Treatment.—Leeches to the lower part of the abdomen or perinæum, hot baths, and warm fomentations; a good dose of calomel, followed by castor-oil, to divert irritating matters from the kidneys; opium by mouth, or by enema, or suppository, in sufficient doses thoroughly to allay pain, and the bicarbonate of potass, neutralized with lemon-juice, or F. 58, 78.

VII. CHRONIC INFLAMMATION of the bladder (*catarrhus vesicæ*) is a very frequent consequence of irritation from stricture, diseased prostate, or stone, and from gout.

Symptoms.—Micturition frequent, and attended with scalding pain; the urine loaded with muco-purulent matter, which is sometimes tinged with blood, sometimes yellowish and puriform, but more generally grayish, streaked with white, alkaline, and excessively viscid, so as to stick to the bottom of the chamber-pot when turned upside down. In the early stages there is but little mucus, and the urine may remain acid; but as the disease advances, the quantity of mucus becomes enormous, and the urine is voided of a brownish hue, and of a most offensive ammoniacal odour. Moreover, it may clog the urethra, and cause retention of urine; a kind of retention difficult to manage, because the mucus clogs up the eyes of the catheter. In this stage there is very frequent desire to make water, and constant pain above the pubes. In general, the mucus contains *phosphate of lime*, which may be seen in it in white streaks, and which is apt to collect and form a stone in the bladder.

Ulceration.—Perhaps the mucous membrane of the bladder may ulcerate, and after death it may be found as cleanly dissected from the muscular coat as if it had been done with a knife. This will be attended with an intense aggravation of the pain and frequency of

micturition, and with a dark colour of the urine owing to the admixture of a little blood which exudes from the ulcerating surface, and which, after the urine is passed, sinks to the bottom like coffee-grounds. The quantity of purulent deposit is increased with occasional shreds of mucous membrane, and lymph, and sometimes small clots of blood. The bladder frequently throws out flakes of lymph, which become encrusted with patches of phosphate of lime. Moreover, it becomes exceedingly thick (the common opinion is that it is hypertrophied; Mr. Hancock finds that the thickening is inflammatory); and portions of it are apt to form pouches which are soon filled with mucus, or with phosphatic calculi. Finally, disease of the kidneys ensues, and the patient dies.

Treatment.—In the first place, if there is a stricture, or enlarged prostate, or stone in the bladder, proper measures should be taken for their removal or relief. In the next place, if the symptoms are at all severe, the patient should keep himself in the recumbent position as much as possible, with the pelvis elevated. Thirdly, if there is at any time a great aggravation of pain, and the strength is pretty good, a few ounces of blood may be taken by cupping on the sacrum or perinæum; but, as a general rule, all lowering measures are injurious. Pain and irritation are to be allayed by the hip-bath, and by enemata or suppositories of opium. Opiate plasters to the sacrum are sometimes of use. The bowels should be kept properly open by mild aperients. The diet should be nourishing, but plain; with weak brandy or gin and water, or sound sherry, for drink.

Of medicines, the most useful, according to Brodie, is the root of the pareira brava. Uva ursi, buchu, Chian turpentine, cubebs, copaiba, and tinct. ferri mur. in small doses three times a day, are remedies of similar virtues. Hyoscyamus or opium, and small doses of mineral acids, if the urine is highly alkaline, may be added to any of them. The sulphate of zinc may also be highly useful, F. 9, 181, 182, &c.

Injections into the bladder are not to be thought of when there is acute inflammation of the bladder, and blood mixed with the mucus, but they are highly serviceable in chronic cases, by washing out the decomposed stinking urine and mucus. Injections of simple warm water are very useful: but very dilute nitric acid (♏i.—ii.—ad ℥iss. aq. destil.) is of great service when the urine is highly ammoniacal. We should have a catheter with a double passage, and may throw in the water in a continuous stream by a syringe, or else may irrigate the bladder, by attaching a caoutchouc tube to each orifice of the catheter; one being dipped into a basin containing the dilute acid; the other into a receiver. Injections of the nitrate of silver have also been used: these require a catheter of very pure silver strongly gilt; those of the acid may be passed through the nickel silver instruments used in lithotrity; or with an elastic bottle and elastic catheter.*

In the excessively painful case of ulceration of the bladder, opium

* See Coulson on the Bladder, &c., 4th edit., p. 170; G. Harley, Lectures; Med. Times and Gaz., Nov. 5, 1864.

given regularly and largely, and introduced into the rectum, is the chief remedy. Injections into the bladder of strong solution of extract of poppies, or of salts of morphia, may be tried.

VIII. CANCER and EPITHELIOMA sometimes affect the bladder either in the form of solid deposits, or of vegetations. The ordinary symptoms are frequent desire to make water; and uneasiness in the region of the bladder, aggravated after micturition, and often extending to the glans penis, perinæum, rectum, and groins. The urine is generally turbid, and deposits an adhesive purulent mucus, and it is very frequently mixed with blood, in irregular clots; and with these, portions of cancerous substance, or of epithelial granulations, are sometimes intermingled. These symptoms, combined with the absence of a calculus, and the probability perhaps of detecting a tumour within the bladder by means of the sound, or by examination of the rectum; or the tumour formed by the thickened bladder in the hypogastrium, and microscopic examination of fragments which pass, are the chief means of diagnosis. The epithelial granulation depicted at p. 111, was taken from the urine of a gentleman who died of epithelioma. The *treatment* consists in allaying pain by opiates, and in checking hæmorrhage and catarrh of the bladder by gallic acid or tincture of steel, and in giving an abundant diet.

IX. VILLOUS VASCULAR GROWTH.—A growth of excessively fine arborescent tufts, consisting, like the villi of the chorion, of loops of large capillaries, and clothed with a cell-growth—generally proving early fatal from profuse hæmorrhage. Whether the growth be in its essential nature really vascular or warty, or epithelial or cancerous, or sometimes one or the other, is yet uncertain. Mr. Partridge has collected some cases of this malady, and thinks that the frequent presence of blood in the urine, with no other morbid condition to account for it, is the best diagnostic sign.

X. POLYPUS of the bladder will display many of the symptoms of stone, but may be distinguished by not being moveable. It has been extirpated.

XI. TUBERCULOUS disease; abscesses bursting into the bladder; and cancerous or corroding ulceration spreading from the bowels, rectum, or vagina, must be treated on general principles.

SECTION VII.—DIAGNOSIS OF BLOOD, ALBUMEN, PUS, AND EPITHELIUM IN THE URINE, DISEASE OF THE KIDNEYS, HÆMATURIA, AND SUPPRESSION OF URINE.

I. ORGANIC DEPOSITS IN THE URINE.—This is the most convenient place for giving a brief description of those organic substances which are occasionally mixed with the urine, through disease of the organs which secrete it, or through which it passes. For a complete account of the subject, we must refer to Dr. George Johnson's work on the kidney, and to Dr. Lionel Beale on the "Microscope in Clinical Medicine." Here we can find room for a few practical remarks only.

1. *Blood* is very frequently found in the urine, rendering it dark and smoky if the quantity is but small, but betraying itself by red clots if the quantity is large. The blood-cells may be detected by the microscope, and the serum by the test to be presently mentioned. If it proceed from the secreting portion of the kidney, it will most likely be in small quantity, and uniformly diffused through the urine; and fibrinous moulds of the kidney tubules will be found in the sediment, and may be detected by the microscope. If the blood comes from the pelvis of the kidney, it may be in larger quantity, and there may be worm-like clots moulded in the ureters. (See *Hæmaturia*, p. 637.)

2. *Serum*, without red particles (*albuminuria*), is very frequently mixed with the urine; when the kidneys are affected with any of those forms of degeneration or chronic inflammation known by the collective term Bright's disease; or when, without original disease in themselves, they are exceedingly congested from pregnancy, disease of the heart, or any other cause. It is not at all unfrequent in the urine of children at the commencement of the exanthemata, or, properly speaking, in most acute diseases. Serum may be detected by the discovery of its *albumen*, the presence of which causes serous urine to be commonly known as *albuminous urine*.

To detect albumen, heat a small quantity of filtered urine to the boiling point, in a test-tube over a spirit lamp; when the albumen will coagulate, and, according to its quantity, may either produce a mere opacity, or may even solidify the entire specimen heated. If the urine

* Small globules; blood, nuclei, small epithelial cells, and spherules of oxalate of lime. 2. Pus. 3. Epithelium from the bladder; the typical form, a long oval, pointed at each extremity, with central nucleus; the younger cells spherical and pellucid; the older ones flattened, often full of granules or oil. 4. Small casts from the kidney, consisting of fibrinous matter entangling few epithelial cells; two of these cells distinct. 5. Triple phosphate.

be alkaline, this test will fail, because then heat alone will not coagulate the albumen; and, moreover, heat alone may cause a deposit of white phosphates; therefore a few drops of nitric acid should be added after the boiling, which will dissolve the precipitate if phosphatic, but not if albuminous, and will throw down the albumen if the urine is alkaline.

3. *Fibrine* in the urine, when present in large flocculi from any ulcerated surface in the bladder, is readily distinguished. This substance, however, is most interesting when moulded in the tubules of the kidney, and accompanying albuminous urine; thus giving evidence of the seat of the effusion. These fibrinous casts of the tubuli uriniferi may vary much in size and appearance. They may be small and transparent, or large and transparent; or they may contain kidney epithelium in large or small quantity. When small, they show that they have been moulded in tubules *not deprived of epithelium*.

4. *Epithelium*, from any part of the urinary organs, may be present in urine. Here we may recall to the recollection of our readers, that under slighter degrees of irritation the uniting medium which gives consistence to any epithelial or cuticular layer becomes loosened, the epithelium is formed in greater abundance, and is shed or *desquamated* more rapidly than natural. Under higher degrees of irritation or inflammation, the entire epithelial covering is stripped off or *excoriated*—a state of things usually followed by the evolution of pus globules on the inflamed surface. 1. The small round gland epithelium from the *kidney*, and the nuclei of disintegrated epithelium cells, are often found in small quantity in the urine when containing oxalate of lime, or when irritating from any other cause. 2. The kidney epithelium may be agglutinated by fibrinous effusion, and may be found in the sediment of albuminous urine in the form of *epithelial casts*, in those acute and chronic inflammations which Dr. G. Johnson calls *desquamative nephritis*. 3. The same epithelial cells and casts also may be found loaded with oil globules in certain stages of some varieties of Bright's disease. 4. The *epithelium from the pelvis, ureters*, and especially from the *bladder*, is often found in great abundance when these parts are irritated by the urine, or by any other cause. The writer has found immense quantities in the urine after difficult labours; it presents itself as a purulent-looking deposit, seen under the microscope, to consist of columnar or oval cells, of very various shapes and sizes, with single nuclei, the larger and older cells often full of granular matter, and almost disentegrated. The urine is not albuminous of necessity. (See fig. 3, p. 633.)

5. *Mucus*, a viscid, stringy, structureless substance, coagulated by acetic acid; alkaline in its reaction, when proceeding from the bladder and fauces; acid, when coming from the vagina; not albuminous; often containing large quantities of phosphate of lime, and having the property of rendering the urine alkaline, and of precipitating triple phosphate. It usually contains some amount of desquamated epithelium, and a few globules, perhaps epithelial nuclei.

6. *Pus* may be present in the urine, through suppuration of any

part of the mucous lining of the urinary passages, or from an abscess in some contiguous part which has burst into them. It generally falls to the bottom of the vessel containing the urine, "forming a dense homogeneous layer of a pale-greenish cream colour, seldom hanging in ropes in the fluid, like mucus, and becoming, by agitation, completely diffused through it. The addition of acetic acid neither prevents this diffusion, nor dissolves the deposit. If a portion of the deposited pus be agitated with an equal quantity of liquid potasse, it forms a dense, translucent, gelatinous mass. On decanting some urine from the deposited pus, the presence of albumen may be detected by heat and nitric acid."* The pus globules may be recognised under the microscope, and the addition of acetic acid reveals the characteristic nuclei. 1. When pus comes from the *uriniferous tubes*, the kidney being in a confirmed state of suppurative disorganization, it may sometimes be found moulded in the form of the tubules; but at all events it may be presumed to come from this source, if constantly present in the urine, and equably diffused through it, and if there are the other signs of kidney disease to be presently described. 2. Pus from the bladder will probably be mixed with large quantities of mucus, constituting muco-purulent matter. 3. Pus from an abscess will be variable in quantity, and not equally diffused. We must here remark that a few pus globules are often mixed with epithelial debris without the urine being albuminous.

7. The *Echinococcus* occasionally infests the kidney, producing severe disturbance. Small cysts, containing the animals, with their characteristic hooklets, p. 173, may be found in the urine, as in a case lately published by Dr. Herbert Barker. Turpentine in diuretic doses is the best means of dislodging them.

II. Acute Inflammation of the Kidney (*Acute Nephritis*) is sometimes caused by blows on the loins, or by the irritation of renal calculi, but is very rarely an idiopathic primary affection. The *symptoms* are, burning pain and tenderness in the loins; colicky pains in the belly; the urine scanty and high coloured, and the bladder irritable, so that there are constant attempts at micturition; fever and great thirst, and vomiting. The remedies are—cupping, leeches, and castor-oil—repeated doses of calomel, opium, and antimony, with colchicum if the habit is gouty; warm baths, or warm fomentations to the loins, and barley-water and other demulcent drinks.

III. Chronic Disease of the Kidneys, when it comes under the surgeon's care, is generally a consequence of long-standing disease of the urethra or bladder. When the bladder has been subject to frequent distension through stricture or enlarged prostate, and its mucous membrane inflamed, the ureters are liable to become distended and converted as it were into subsidiary receptacles for the urine, so that all the violent strainings to evacuate it tell upon the kidneys; and these become diseased, through the mechanical irritation, and the extension of inflammation from the bladder. The pelvis and infundibula undergo suppurative inflammation—a state described

* Golding Bird on Urinary Deposits, 2nd edit., p. 273.

as *pyelitis*, and then the disorganization of the uriniferous tubes easily follows.

Symptoms.—A person who has long been labouring under some chronic affection of the bladder, begins to complain of general weakness and languor, both bodily and mental. The sleep is unrefreshing, the tongue nauseous, and the appetite lost. There is frequent pain of a weak aching character in one or both loins; occasionally shooting

down to the testicles or groins. The urine is *albuminous*; it is generally pale-coloured and opaque when passed; sometimes it is tinged

* This engraving, from a preparation in the Middlesex Hospital Museum, represents the beginning, middle, and end of a fatal case of disease of the urinary organs. It shows a tight stricture about three inches from the extremity of the penis; the urethra dilated behind it; another stricture in the membranous portion; false passages and abscess around; the bladder contracted in size but enormously thickened; the ureter dilated and tortuous, looking like an intestine; and the kidney expanded and atrophied, with scarce any of its secreting substance remaining.

with blood, and sometimes containing shreds or flakes of lymph. As the disease proceeds, it deposits pus after standing. Fits of sleepiness, headaches, and sickness come on. These cases are almost sure to end fatally. Sometimes the patient dies of exhaustion and obstinate vomiting; sometimes of suppression of urine and coma; sometimes in a sudden fit of severe shivering; and sometimes of a rapid attack of inflammation of the pericardium or some other serous membrane. The kidneys are found after death to be soft and disorganized; readily separating from their capsule, which, however adheres firmly to the flat and cellular tissue of the loins; and most likely they are dilated into cysts; the secreting tissue being spread out over the dilated pelvis and infundibula.

IV. Abscess in the Kidney.—This may be suspected if dull pain in the loins and repeated shivering follow the symptoms of nephritis. Sometimes the abscess bursts into the ureter, and an immense quantity of pus is discharged with the urine. Abscess of the kidney also sometimes bursts on the loins, and the patient has been known to recover.

V. Treatment of Chronic Kidney Disease.—On this subject we can but give a few general hints. When there is much tenderness in the loins, a moderate quantity of blood may be taken by cupping. Blisters or plasters of the emp. ammoniaci, or of opium or belladonna may also be of service. The skin should be kept warm by flannel. It will be necessary to provide for the free action of the liver and bowels, and to keep up the secretion of the kidneys, if deficient, by the milder sorts of diuretics, such as small doses of neutral salts; the infusions of buchu, and uva ursi, of carrot-seed, or of the root of parsley. The tartrate of iron will be of great service. The diet generally should be plain, but nutritious. If the loss of albumen is great, it should be combated by gallic or tannic acid, or tincture of galls or rhatany, or decoction of oak-bark internally, and by the use of strong essence of meat. F. 198.

VI. Hæmaturia, or *Bloody Urine*.—The seat of the hæmorrhage may be either the kidneys, or the prostate or bladder. 1. Hæmorrhage from the *kidney* may be caused by the irritation of renal calculi, or by blows on the loins; by the congestion consequent on scarlet fever; and by other diseased states of the whole system, as in typhus and scurvy.

At the Cape of Good Hope and some other parts of the world a form of hæmaturia is endemic, and is caused by the presence of a minute worm in the veins of the kidney.*

2. Hæmorrhage from the *prostate* or bladder may be caused by the rude introduction of instruments, or by the irritation of stone; or by the existence of an ulcer or fungoid tumour, of which, in fact, it is often the earliest manifestation. When the blood is derived from the bladder, some portion of it often flows pure after the urine is discharged,

* John Harley, Med. Chir. Trans., 1864, and Hooper's Physician's Vade Mecum, 1864.

and it is in much greater quantity, and often in larger and more irregular clots than when derived from the kidneys; moreover, the pain in the back, and other signs of renal irritation that accompany bleeding from the kidney, will not be present.

Treatment.—When hæmorrhage from the kidneys is attended with inflammatory symptoms, cupping, purging, and the acetate of lead are indicated; when with symptoms of debility, the dilute sulphuric acid, alum, tinct. ferri muriatis, or gallic acid. Cold may be applied to the loins and hips by means of bladders of ice. In hæmorrhage from the bladder a catheter should be passed and be retained, in order to prevent both accumulation of blood in the bladder and straining efforts at micturition. If the hæmorrhage is obstinate, the bladder may be injected with cold water containing a scruple of alum to each pint; and if much blood have coagulated in the bladder, it may be necessary to break it down by repeated injections of water. Small doses of turpentine will sometimes check a hæmorrhage from the bladder, which resists all other means.

VII. SUPPRESSION OF URINE (*Ischuria Renalis*).—When the kidneys have been long abused by inordinate indulgence in strong drink, and are falling into disease, or when they have become diseased, they are liable suddenly to lose their function of secreting the urine. The consequence of this is, that the urea and other elements of the urine accumulate in the blood; the patient complains of great uneasiness in the head and loins; he becomes first drowsy, and then comatose, and dies in four or five days. This affection is alluded to here in order to hint at the diagnosis between it and retention of urine. In suppression, if the catheter is introduced, the bladder will be found empty; whereas in retention, whether from stricture, or from diseased prostate, or from palsy of the bladder, it may be felt full and distended above the pubes.

SECTION VIII.—URINARY DEPOSITS OR GRAVEL.*

In the urine are washed away the refuse matters derived from digestion, assimilation, and the wear and tear of the body. Any deviation, therefore, from a healthy state of digestion and nutrition is sure to be followed by a deviation from the healthy properties of the urine. So extensive and complicated is the chemical and physiological history of these changes, that we can but refer to the works of Prout, Liebig, Golding Bird, Bence Jones, Owen Rees, Garrod, Hassall, Lionel Beale, and George Harley, and must confine ourselves to the immediate bearings of the subject on surgical practice.

We may observe that when the surgeon examines the urine, since it varies extremely in its properties at various hours of the day, the whole

* For information on the subject of this and the following sections, consult Prout on Stomach and Urinary Disease; Garrod, Lancet, 1849; Bence Jones, Lancet for 1850, vol. i.; Brodie on Diseases of the Urinary Organs, 3rd edition; Golding Bird on Urinary Deposits, 3rd edit.; Hassall, Lancet, 1850-53; Lionel Beale on Urine, Urinary Deposits, and Calculi, 2nd edit. 1864; Dr. G. Harley's Lectures in Med. Times and Gaz., 1864.

quantity that is passed during twenty-four hours should be collected into one vessel; so that its acidity and specific gravity and quantity may be fairly estimated.

We may observe as a further preliminary, that when a precipitate is let fall from the urine after it has been voided, it is called a *sediment;* that when precipitated in the bladder or kidneys it is called *gravel;* and that gravel lodging in any part of the urinary passages may concrete into *stone*. Further, that when the urine of any person habitually presents any one kind of deposit, he is generally said to have a corresponding *diathesis;* as the lithic diathesis, &c.

The principal diseased conditions we are at present concerned with are those in which the urine deposits—1st, uric or lithic acid; 2ndly, oxalate of lime; 3rdly, phosphates.

1. Lithic, or Uric Acid, or Red Gravel.—This is deposited in the form of minute crystals, tinged with the colouring matter of the

urine. It generally indicates a highly acid state of the urine, through which it is precipitated from the ammonia and other substances which ought to be held in solution.

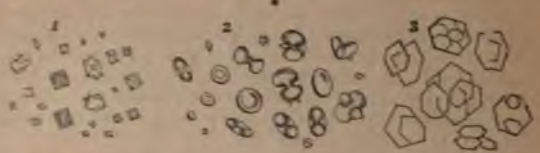
The amorphous *lithates of ammonia, soda, and lime* form a very common sediment, varying in colour from nearly white to dark red or yellow. The urine from which it is deposited is generally acid; clear when passed, but clouded as it cools; and this sediment may readily be distinguished by its dissolving when heated slightly.

Lithates, deeply tinged by pink or brick-dust colouring matter, form the sediments observed in fever, gout, and chronic diseases of the liver. The lithate of soda is sometimes found.

II. Oxalate of Lime is generally deposited from urine which is highly acid, and contains much lithate. It is in the form of minute

* 1. Lithic acid. 2. Lithates in powder, and spherules of lithic acid or lithate. 3. Basic phosphate. 4. Torula.

octahedral crystals, invisible except by the microscope. The dumb-bell form is rare, and probably another form of oxalate. (Dr. Beale.)



III. PHOSPHATIC DEPOSITS may arise in two ways. First, from excessive secretion of the mucus of the bladder. If the bladder be irritated from any cause so as to create this condition, the urine may be rendered alkaline by decomposition of its urea into carbonate of ammonia. But this is far from being any evidence of a *phosphatic diathesis*. For example, the writer has often found crystals of lithic acid, in highly-ammoniacal urine—which has doubtless been secreted acid—in gouty cystitis. Thus, an irritating—possibly over-acid—state of the urine may be the cause of ultimate alkalinity.

Secondly, they may arise from a primarily alkaline, or insufficiently-acid state of the urine, through which the phosphates of lime and of magnesia are precipitated: but they do not prove that *phosphoric acid is in excess* in the urine. The most common cause of alkalescence, or of deficient acidity in the urine, is surmised by Bence Jones to be excessive acidity of the stomach. Thus, as the writer of this work stated in the edition of 1841, the urine is often loaded with triple phosphate when the stomach is full of acid. In such a case the urine if alkaline is said to be so from preponderance of potass or soda. The ammoniacal urine which is commonly found in chronic cystitis, in disease or injury of the spinal cord, in the latter stages of prostatic disease, and under any circumstances which cause habitual retention of urine, is the result of putrefaction. When urine is alkaline from ammonia, reddened litmus-paper steeped in it, and afterwards heated, recovers its red colour, which is not the case when alkalescence arises from the presence of fixed alkali. The varieties of phosphatic deposit are—1, the *triple phosphate* of ammonia and magnesia, which appears in sparkling prismatic crystals on the surface of the urine (fig. 5, p. 633); 2nd, basic triple phosphate, formed by the addition of ammonia either in the bladder or out of it (fig. 3, p. 639); and 3rd, the phosphate of lime, a white amorphous powder, generally associated with mucus.

Pathological Relations.—The lithic sediments, crystalline or amorphous, often accompany gout, and may exist in conjunction with a highly sthenic plethoric condition; not that this is always the case, for they may indicate debility, mal-assimilation, or excessive fatigue. The

* 1. Oxalate of lime crystals. 2. Oxalate of lime in pellucid spherules; single, double (or dumb-bells), and quadruple. From the urine of a woman whose only symptom was extremely distressing palpitation. 3. Cystine.

oxalic generally indicate feeble powers of assimilation, and exhaustion of the nervous system. The phosphatic, when not arising from changes in the bladder, usually indicate low dyspepsia. Any deposit may exist occasionally in small quantity unnoticed; it is the constant or abundant presence which is the important evidence of disease.

When a patient is secreting the red crystalline gravel, or has, to use the vulgar phrase, a *fit of the gravel*, he usually complains of great pain in the loins and bladder; frequent desire to make water; and aching of the testicles and hips. Sometimes these symptoms are attended with great feverishness; sometimes with mere languor and dyspepsia.

When oxalate of lime is abundant, the whole urinary organs are apt to suffer extremely; with frequent micturition; aching in the loins and bladder; great irritation of the genital organs; often these symptoms are combined with peculiar lassitude, fits of headache, sour perspiration, nettle-rash, extreme despondency, and other signs of obstinate indigestion, and of a disordered condition of the blood. Aching of the eyeballs has been often noticed by the author.

Treatment.—The treatment of urinary disorders has of late years been made too dependent on a superficial chemical examination of the urine; it being the custom to give acids if the urine is alkaline, and so forth, without sufficient regard to other circumstances. The author stated in an edition of this work published in 1841, that this summary method of treatment was essentially erroneous. Subsequent experience has confirmed his ideas on this point; and he would advise his readers, under all circumstances, to treat the general health on rational principles, and leave the urine to take care of itself.

The first thing to notice, is the patient's blood-making powers, and his habits. Because if lusty and red-lipped, and a high liver, and troubled with lithic gravel of no long duration, he will generally be speedily relieved by full purgation; by reduced diet, warm baths, and liq. potassæ in drachm-doses thrice daily after meals. The diathesis will be kept at bay likewise by habits of early rising, by exercise enough to make the skin eliminate acid; by great temperance in meat and beer or wine; by freely eating fresh vegetables, and especially cabbage, water-cresses, and fruit, provided always that they cause no inconvenience to the stomach; and by occasional effervescing, alkaline, or saline draughts—such as lemon-juice, potass-water, Seltzer-water, or F. 58, 60, 61, 70, 72, 73, &c. Hot air or vapour baths may be of use.

But far different must be the treatment if the urinary deposit, be it what it may, is created, not by an excess of material in the system, but by feebleness of the powers which ought to convert the food into healthy flesh and blood, or by overwork of mind or body. In these cases the prime object must be to strengthen the digestion; and the means are the following—1. It is often beneficial to begin the cure by freeing the liver and bowels of black offensive scybalous motions, by a grain or two of calomel, with colocynth, or with some tonic purge, to carry it off, F. 37, 41, 50, &c. The motions should be inspected, and the medicine be repeated at discretion till they are rendered healthy.

2. There are few remedies comparable to *change of air*, including, as it must, change of diet, water, habits, and occupation, for the cure of all disorders of mal-assimilation. 3. *Alkalies*, such as F. 77, 79, may be given in small doses after meals to the infinite comfort of the stomach, if the patient complains of sour eructations, flushed face, flatulence, &c., and this, no matter whether the urine is ammoniacal or not. 4. But the most important medicines are *Tonics*. Of these one of the most useful is the nitromuriatic acid, F. 22, which may always be given with benefit on an empty stomach, if the patient likes it; if he feels that it takes away that nauseous, flabby, alkaline condition of mouth which so commonly accompanies a low digestive power. But the other mineral acids—bark, quinine, nux vomica, and other bitters; the sulphates of zinc and iron; and the muriated tincture of iron—will all be found useful. 5. *Conium*, or even *opium*, introduced into the rectum as a suppository is sometimes necessary to allay local irritation, especially in phosphatic and oxalic cases. It may also be necessary as a means of procuring sleep, and preventing the nervous system from being worn out by its own irritability. 6. The *diet* should consist of those substances which are most readily convertible into good flesh and blood, and least liable to undergo degeneration during their solution in the stomach. Meat, good soup, milk, eggs, good bread, cruciferous vegetables—brandy and water, pale sherry, good Bordeaux, and bitter ale—show the kind of substances to be preferred; and pastry, sago, slops, and bad wine the things to be avoided.

SECTION IX.—THE VARIOUS KINDS OF STONE.

The various deposits spoken of in the preceding section may, as we observed, lodge in some part of the urinary organs, and concrete into stone. There are altogether fourteen species, many of which are excessively rare. The principal ones are, the lithic, phosphatic, and mulberry.

I. LITHIC ACID stones are generally oval, flattened, fawn or mahogany coloured, and on a section are seen to be composed of concentric laminæ. *Tests.*—This acid may be dissolved by boiling in *liquor potassæ*; it burns away almost entirely before the blowpipe with an odour of burnt horn, and if digested in a small quantity of nitric acid, and evaporated at a very gentle heat, it leaves a residue, which, when cold, becomes purple, if exposed to the vapour of ammonia (*murexide*).

II. LITHATE OF AMMONIA rarely forms a stone, because it is tolerably soluble in warm urine. *Tests.*—It may be known by the same tests as the preceding, and, besides, it evolves ammonia when treated by liq. potassæ.

III. PHOSPHATE OF LIME or *bone-earth* stones are rare. They are pale brown, friable, and laminated. *Tests.*—Soluble in nitric or muriatic acids, and precipitated by liq. ammoniæ; quite infusible. (Beale.)

IV. TRIPLE PHOSPHATE (*of ammonia and magnesia*) forms white or pale-gray stones, composed of small brilliant crystals. *Tests.*—Evolves

ammonia when treated with liq. potassæ; is soluble in acetic or muriatic acid; precipitated again by ammonia in form of crystals of basic phosphate; fusible under the blowpipe, its fusibility varying with the amount of triple phosphate.

V. The FUSIBLE STONE is formed of the phosphate of lime and triple phosphate mixed. It forms a white friable mass like mortar, and is very fusible.

VI. The MULBERRY STONE is composed of oxalate of lime. It is dark red, rough, and tuberculated. *Tests.*—Not dissolved by boiling in potass; soluble in nitric acid; if exposed to the blowpipe, the acid is burned off, and quicklime is left, which, if moistened, reddens turmeric paper.

VII. Besides the above, stones are sometimes composed of *cystine*, a peculiar animal substance, containing much sulphur, soluble both in alkalies and dilute mineral acids, but not in acetic acid; precipitable in peculiar six-sided crystals by acetic acid from its solution in ammonia (see fig. 3, p. 640); also of *carbonate of lime*; of the *fibrine* of the blood, and of *xanthic* or *uric oxide*, a peculiar animal matter allied to uric acid. The lithate of soda, the lithate and carbonate of magnesia, and silica, are also rare ingredients in calculi.

Alternating Calculi.—Sometimes stones are composed of alternate layers of lithic acid and oxalate of lime; and very commonly the outer layers of a stone are phosphatic, the nucleus lithic or mulberry. The phosphates commonly succeed the other deposits, being surely produced after a time by the irritation of the mucous membrane; but the lithic and mulberry never coat the phosphates.

SECTION X.—STONE IN THE KIDNEY AND URETER.

Symptoms.—The symptoms of stone in the kidney are, pain in one or both loins; irritation and retraction of the testicles; the urine bloody after violent jolting exercise; and occasional fits of inflammation of the kidney. Stones in the kidney are most frequently composed of lithic acid, which will be known by the deposit of red sand from the urine. The oxalate of lime is more rare. Crystals both of this substance and of lithic acid have been detected in the tubuli uriniferi. Phosphatic stone in the kidney is still more rare. When it does exist, it is generally composed of the phosphate of lime, and indicates incipient disease of the organ.

Treatment.—When a stone is ascertained or suspected to exist in the kidney, the indications are, *first*, to examine the general health, and treat any derangement according to the rules laid down in the previous sections; *secondly*, to endeavour to expedite the passage of the stone through the ureter, by diluents and diuretics; and by the *cautious* use of exercise so as to dislodge it; and, *thirdly*, to remove inflammation if it exist, by cupping on the loins, by mild aperients and copious enemata of warm water, by opium or henbane, and by warm baths or fomentations. Pounded ice applied to the loins gives great

relief when much burning pain is complained of, but it must be used with caution.

The ordinary and most favourable event of stone in the kidney is, that it descends through the ureter into the bladder. In some cases, however, it remains in the kidney, increases in size, completely fills up the pelvis and infundibula, and causes the organ either to waste away or to suppurate; the abscess bursting either into the colon, or on the loins.

The PASSAGE OF A STONE THROUGH THE URETER causes the following symptoms:—The patient complains of sudden and most severe pain, first in the loins and groin, subsequently in the testicle, and inside of the thigh. The testicle is also retracted spasmodically. At the same time there are violent sickness, faintness, and collapse, which may last two or three days, and are only relieved when the stone reaches the bladder.

Treatment.—The warm bath, large doses of opium, emollient enemata, and plenty of diluents, are the obvious remedies, and an active purgative may perhaps be tried if the process is slow.

Sir B. Brodie has shown that there is a set of symptoms which sometimes affects gouty people—consisting of pains in the loins reaching to the groin and neck of the bladder, and scanty, high-coloured urine—which very much resemble those caused by the passing of a stone through the ureter. They may be distinguished by the absence of faintness and vomiting, and readily yield to purgatives and colchicum.

SECTION XI.—STONE IN THE BLADDER.

STONE IN THE BLADDER produces the following *symptoms:* 1. Irritability of the bladder, frequent irresistible desire to make water. 2. Occasional sudden stoppage of the stream of water during micturition, from the stone falling on the orifice of the urethra; the stream probably flowing again if the patient throws himself on his hands and knees. 3. Occasional pain at the neck of the bladder, always severest after micturition. 4. Pain in the glans penis. If the patient be a child, he is always attempting to alleviate this pain by pulling at the prepuce, which becomes extremely elongated. 5. Occasional passage of blood and crystals of uric acid or oxalate with the urine.

6. *Sounding.*—But none of the above symptoms must be depended on alone. The existence of the stone must be made sensible to the ear and fingers, and the instrument employed for this purpose is a sound, a solid iron rod, the size of a medium catheter, not large enough to distend the urethra. Its handle should be polished, and the rest smaller than the end, so as to move easily in the urethra, and the surgeon should possess several, of various lengths. The form of sound used by Mr. Fergusson is the best.

One of these instruments should be introduced at a time when the urinary organs are comparatively free from irritation, and the health from disturbance. The patient should be on his back on a high bed,

the pelvis raised on a pillow, and the bladder nearly, but not quite, full. In order to insure perfect quietness, and to prevent pain to the patient, he should be put under the influence of chloroform, and if the bladder is empty, tepid water should be injected. The sound should be carefully moved about, to examine every part of the bladder, and if there is a stone of any size it will most probably be heard to strike and felt to grate upon it. If nothing, however, is discovered, the patient may be made to turn on one side, or to sit upright, or the finger may be passed into the rectum; or a sound with the same abrupt curve as the lithotrite may be used to explore the *bas fond* of the bladder, behind the prostate; or a catheter may be introduced, and the stone may perhaps be felt to strike against it as the urine flows away. But if the symptoms are well marked, the surgeon must not be contented with one unsuccessful examination.

Diagnosis.—In sounding there are two *errors to be avoided*. *First*, that of assuming that there is no stone, when none can be felt. The chief circumstances which occasion difficulty in this respect are, enlarged prostate; cysts or pouches, in which the stone can be hid; and small size of the stone.

The second error is that of taking something for a stone which is not. Thus polypous or pendulous growths, portions of the bladder hardened, or rough from ulceration or from fibrinous deposit, or encrusted with phosphates; even the spine of the ischium, exostoses, and tumours of neighbouring parts, have at times been mistaken for stone.

The symptoms of stone vary in *severity*:—1, according to its size and roughness; 2, according to the state of the urine; 3, according to the condition of the bladder, whether healthy or inflamed. They may be very slight for years; in fact, a little pain in micturition and bloody urine after riding may be the only inconveniences. But after a certain period the bladder becomes more and more irritable, and finally inflamed; the urine alkaline, and loaded with viscid mucus and phosphate of lime; the strength fails; and finally, after years of suffering, the patient sinks.

The *sources* of vesical calculi are two:—1, the urine; 2, the mucus of the bladder; and calculi are exceedingly liable to form from the latter source, if the prostate is diseased, or if foreign bodies are introduced into the bladder, so as to serve for nuclei. In these cases the stone is invariably phosphatic.

The *composition* of a stone may be judged of, but not always accurately, by the state of the urine. Its *size* may be appreciated:—1, by its composition, for the phosphatic are always the largest; 2, by the time it has existed; 3, by observing the force required to dislodge it from its situation; 4, it may be measured by passing the sound across its surface, or by the urethra forceps or lithotrite, or by Coxeter's hollow sound. Phosphatic stones are of quickest growth; they are softest and most friable. Uric and oxalic stones are of slow growth; they are hard, break into sharp fragments, and give a clearer *ring* or *click* when struck with the sound than do the phos-

phatic. Stones have been known to vary in weight from a few grains to forty-four ounces, and in number from one to one hundred and forty-two. Mr. C. Mayo, of Winchester, extracted one weighing fourteen ounces and a half, but it was broken; the patient lived several years. Gooch tells us that Mr. Harmer, of Norwich, in the year 1746, extracted one entire which weighed nearly fifteen ounces, and the patient lived five years. Sir A. Cooper extracted one entire, weighing sixteen ounces, but the patient died. Dr. Mott, of New York, in 1834 extracted one entire weighing seventeen ounces two drachms and thirty-six grains, from a young man aged twenty-one, who survived five days.* The operation was the bilateral.

Treatment.—The indications are:—1, to get rid of the diseased state of the urine; 2, to allay pain and irritation; 3, to remove the stone. The first and second are to be accomplished by measures which have been already spoken of when treating of gravel and of chronic inflammation of the bladder. The third may be executed in three ways, viz., 1, solution; 2, lithotrity; and 3, lithotomy—each of which requires to be treated of in a distinct section.

SECTION XII.—LITHOLYSIS, OR SOLUTION OF STONE.

Sir B. Brodie long since showed that *phosphatic* calculi may sometimes be dissolved altogether, and sometimes be so disintegrated or reduced in size that they may escape through the urethra by means of the injections of very dilute nitric acid directed for chronic cystitis.

The *Vichy water*, a solution of bicarbonate of soda saturated with carbonic acid, has considerable effect not only on lithic calculi, which it dissolves by virtue of its alkali, but on the phosphatic, which it affects through its carbonic acid, and by disintegrating the animal matter which cements them together.†

Experiments have been made on various alkaline and saline solutions and solutions of lead, aided by the force of galvanism, by Dr. Elliott Hoskins, of Guernsey, Dr. Bence Jones, Dr. G. Robinson, of Newcastle, and others; but they have not been yet brought to any practical result.

SECTION XIII.—LITHOTRITY.

Definition.—An operation for grinding or crushing stone in the bladder into fragments of so small a size that they may be readily expelled through the urethra.

History.—So desirable is this object, that it has been treated of, or attempted, by surgeons in every epoch of civilization; by Hippocrates amongst the Greeks; by Albucasis of the Arabian school; by Franco,

* The writer must thank Wm. Darling, Esq., M.A., M.D., &c., formerly of New York, for this fact; Dr. Darling was present at the operation, and weighed the stone.

† See Dr. Willis's work on Stone; Elliott Hoskins, Lond. Journ. of Med. Oct. 1851; Ranking, vol. xiv. and xvii., quoted from Phil. Trans., 1852. Dr. G. Robinson's pamphlet on Electro-Lithotrity. Lond., 1855.

Guido de Cauliaco, Hildanus, Haller, and others, down to the end of the eighteenth century. The attempts, however, were, as Mr. Coulson observes, isolated, and fruitless, till, in 1813, Gruithuisen, a Bavarian surgeon, published two memoirs on Lithotrity, and described his instruments, consisting of "a straight canula, intended to pass into the bladder and serve as a conductor for a perforator, which was either lance-shaped or dentated; a wire for seizing and fixing the calculus, a handle rapidly moved by a bow-drill, a branched forceps, and a hook for the purpose of crushing the fragments of stone when divided by the perforator." It does not appear, however, that these instruments were used either on the dead body or on the living, and the project was soon forgotten.*

Following the historical summary prefixed to Mr. Coulson's very complete and elaborate Lectures on Lithotrity, originally published in the Lancet for 1852, and since collected into a separate volume, we find that the person who next took up the subject was Civiale. In the year 1817, then a poor student, he constructed the models of some instruments, and the next year applied to the French Minister for pecuniary aid towards carrying on his experiments. His chief instrument was a double metallic tube, the inner tube having six elastic steel branches at its extremity: these were intended to grasp the stone, which was then to be bored by a lance-shaped *lithotriteur*. Pursuing his researches, Civiale, in 1819, reduced the six branches of his instrument to four, and in 1820 to three. He added a bow-drill; and with these improved instruments experiments were publicly made in 1822, at the Hospital of La Pitié, and in the dissecting-rooms of the Faculty.

In 1819, Mr. Elderton published in the April No. of the 'Edinburgh Med. and Surg. Journal' a proposal for attacking calculi with a curved two-branched instrument and perforator. But Elderton's proposal, like Gruithuisen's, was unfruitful; Civiale's was more fortunate.

In April 1822, M. Amussat described an instrument which he had constructed for *crushing* stone. This was a strong two-bladed forceps acting laterally, concealed in a canula, and worked by a lever. In June of the same year, M. Leroy, now better known as Leroy d'Etiolles, produced an instrument, consisting of a double canula, of four long watch-springs, attached to the extremity of the inner canula, to catch the stone, and of perforators worked by a bow-drill. In April 1823, M. Leroy produced an improved instrument. The appearance of this drew M. Civiale from his retirement; but not till May 1823 did he publish an account of his process. On January 10, 1824, he performed his first operation in the presence of Barons Percy and Chaussier, commissioners appointed by the Faculty. The patient was relieved of his stone in two sittings; a third equally quickly. Thus Civiale is to be regarded as the inventor of lithotrity.

Hitherto we have spoken chiefly of *boring* instruments. The first

* Coulson on Lithotrity and Lithotomy, Lond., 1853.

crushing instrument of any value was manufactured by Mr. Weiss in 1824. It was composed of two blades sliding on each other, and brought together by a screw. This is, in essentials, the instrument used at the present day. Sir B. Brodie, however, thought that the screw would act with such violence on a hard calculus that the

bladder would be injured by the flying off of the fragments; and so for a time it was laid aside.

In 1825, Dr. Haygarth invented a sliding instrument, to which a screw was connected at the suggestion of Mr. Hodgson, who tried it on a patient in the Birmingham Hospital in the same year. To this distinguished surgeon belongs the honour of having first performed the modern operation of crushing by the screw.

But the method which now acquired celebrity, and which was first practised by Heurteuloup in 1830, consisted in hammering the stone to pieces. The patient was confined to a bed of peculiar construction, called the *lit rectangulaire;* and the *percuteur courbe à marteau*—a sliding instrument composed of three blades—was made to seize the stone. This was then broken by repeated blows with a hammer on the other extremity of the instrument, which was fixed securely to a vice. But this plan was fraught with many inconveniences. The instrument was too feeble: in one case it was bent up over the pubes; its blades were apt to become so clogged with pulverised fragments, that they were withdrawn with difficulty, or perhaps not until the orifice of the urethra had been slit up; and the bladder was exposed to injury from percussion communicated from the instrument, and from the violent splitting of the calculus.

* Weiss's Lithotrite with screw force. The upper or male blade is drawn back by the thumb upon A. The scale shows the degree of separation; B, the handle. 1. The end of the blades; 3, end of the blades of a lighter instrument for fragments; 2, end of a catheter scoop for permitting escape of detritus.

Heurteloup's instrument was next improved and simplified by Costello, who seems to have reinvented the two sliding blades which Weiss had designed eight years previously. Mr. Oldham, a gentleman attached to the Bank of Ireland, devised the oval slit in the female blade, for the escape of detritus, shown in figs. 1 and 3. In 1834,

Mr. Fergusson employed the hand-rack and pinion represented in the above cut.

The advantages of the rack and pinion are that the degree of force can be felt by the hand, and that pressure can be alternated with percussion. The latest instruments, however, have a screw, with such modifications as enable the male blade to be drawn back, without reversing the screw. This was devised by Civiale, made by Charrière, and improved by Weiss and Coxeter. The shaft also is smaller than the jaws, so that it can be more readily manipulated in a small urethra; the instruments also are of two kinds—the larger and heavier, with fenestrated female blade, for crushing a stone into fragments—the lighter, such as No. 2 in the preceding page, for further crushing fragments into powder.

The account we can find room for of lithotrity is most imperfect. It is an operation requiring the greatest possible perfection of diagnosis so as to fix on the cases best adapted for it. It demands enormous experience, and involves so many small practical details, that it is quite out of our power to describe them. We can but give a meagre sketch, and must refer the reader to Mr. H. Thompson's work on Lithotomy and Lithotrity, as the fullest, newest, and ablest work on the subject.

The *Preparatory Treatment* necessary consists in correcting any detectable disorder of the digestive organs or general health, and allaying any irritation of the urinary organs, by hip-baths, opiates, and repose. The surgeon should also by bougies dilate the urethra, and by sounding estimate the size of the stone, and the capacity and degree of irritability of the bladder; for so long as that is very irritable the operation must be delayed.

The best patients are those who have a urethra of full size; a blad-

der neither irritable nor paralysed, but capable of holding five or six ounces of urine, and of expelling it.

The great danger of the operation is mechanical injury to the bladder. The great aim should be gentleness. It is generally best not to use chloroform unless the patient much wishes it. The operation is not generally painful; if so, it should be cut short.

The patient should be placed on his back on a couch, with the head on a pillow, the knees gently raised and supported, and a little apart. The pelvis must be raised above the level of the shoulders;—about two inches under ordinary circumstances: but four to six inches if the prostate be much enlarged. The object is to get the stone away from the neck of the bladder, which is the part most liable to injury; much further away, of course, if the prostate be enlarged, otherwise it cannot be reached at all. "The centre of the cavity and space beneath it," says Mr. Thompson, "form the area of operation."

The bladder should contain from four to six or eight ounces of water, and it usually suffices to desire the patient to hold it for a couple of hours before the operation. The cases in which it is most desirable to inject water, are those of atony and flaccidity of the bladder, so that it hangs in folds instead of being equally round.

The instrument, warmed and oiled, is now to be most gently introduced, and it must be passed fully into the bladder. The blades must be coaxed almost into the bladder before the handle is lowered. The next step is to seize the stone. There are two ways of doing this, by bringing the stone to the instrument, by opening the blades—depressing them into the fundus of the bladder, and getting the stone to roll between them;* 2. To apply the instrument to the stone, so as to seize it with certainty, without doing more than *rotating* the instrument in the neck of the bladder. This is neater and safer. The rules for exploring the bladder so as to seize the stone are most minute and precise.

When the stone is fairly grasped, the screw or other mechanical force employed should be made to crush it. Rules are given for finding and seizing the fragments, which of course fall perpendicularly into a very limited area, and perhaps two or three may be seized and crushed at the first sitting, which, however, should not exceed three or four minutes. At the end of the operation it must be seen that the blades are entirely closed, and not choked by detritus, while the instrument is withdrawn.

The subsequent parts of the treatment are these. First, all pain, which is often severe, must be allayed by opium, administered by the mouth, or in the form of enema or suppository, F. 101, 174. Hip-baths, barley-water and other demulcent drinks, and alkaline medicines may be used with the same intention.

The patient should keep in the recumbent position, that the fragments may not fall on the neck of the bladder.

The operation must be repeated at intervals, till every fragment is

* Brodie, Med. Chir. Trans., vol. xxxviii.; F. C. Skey, on the Merits of the Two Operations for Stone, Lond., 1854.

crushed and expelled. In favourable cases there is some degree of scalding and pain, which soon pass off, and allow the operation to be repeated in three or four days. In less favourable cases, there may be severe pain and spasm of the bladder, requiring an interval of six or eight days.

When the stone has been broken into fragments, these may be pulverized with the lighter instrument.

Mr. Thompson's opinion is, that it is best to pulverize a stone thoroughly. The powder comes away without effort. As for fragments of medium size, he thinks they are better left to take their chance. Mr. Fergusson, on the contrary, employs scoops to bring them through the urethra.

After each operation, and especially after the first, the patient should not attempt to make water for some hours; and should remain quietly on his back for two or three days. Probably he will not be able to make water, from the injury which the neck of the bladder has received, and will require the catheter. It may be expedient to make him pass water on his knees, especially if the prostate is enlarged.

If a fragment become impacted in the urethra and cause retention, it must either be gently pushed back into the bladder; or extracted by the urethra forceps, or by probe or hook; or crushed in the urethra; or lastly, be cut down upon from the perinæum.

Contraindications.—The circumstances which render the operation of lithotrity difficult or dangerous, relate 1, to the *urethra;* for if this be naturally small, as in children, or strictured by disease, and incapable of being dilated so as to admit the necessary instruments, lithotomy is to be preferred to lithotrity. In children under puberty, the advantages of lithotrity are few, unless the stone is very small, and can be disposed of at one or two sittings; for the operation of lithotomy at this age gives most favourable results. 2. Unconquerable irritability and contractility of the *bladder*, especially if already thickened by disease. 3. Very great enlargement of the *prostate*, and especially of the so-called third lobe, which hinders the manipulation of the instrument and the escape of detritus. 4. Great size of the stone, such as a larger diameter than two inches, especially if accompanied with much hardness, and if there are more stones in number than two. If these be the contraindications, it will be readily inferred that the

Cases in which Lithotrity may be beneficially resorted to, are those in which 1, the patient is an adult, with a full-sized *urethra;* 2, in which the *prostate* is not enlarged; or at all events, in which, if the prostate be slightly enlarged, the stone is small and friable, the general health good, and the bladder not irritable; 3, in which the *bladder* is free from thickening, extreme irritability, and *purulent* catarrh. Simple mucous catarrh is no contraindication; in fact, being caused by the presence of stone, it will be relieved by that which removes its cause. Lastly, cases in which the stone is single, or in which at least there are not more than two; not large; nor very hard. The oxalic are the hardest and most intractable of all.

This operation may be followed by rigors, and great constitutional disturbance and debility: or by inflammation and abscess in the pelvic areolar tissue, which may prove fatal; but Sir B. Brodie gave it as his opinion, that if prudently and carefully performed, with a due attention to minute circumstances, it is liable to smaller objections than almost any other of the capital operations in surgery; and subsequent experience confirms this opinion fully.

It must be observed, in conclusion, that the benefits of lithotrity are most fully evinced when patients apply for relief at the earliest possible period after the descent of the stone into the bladder.

SECTION XIV.—LITHOTOMY.

Definition.—The best definition is the homely English phrase, *cutting for the stone.*

The *Indication* for this operation may be defined to be, the presence of a stone in the bladder, which it is not judged expedient to remove by lithotrity.

The only *Contraindication* is the presence of such serious organic disease, and especially of the kidneys or lungs, as would render the patient likely to sink from the immediate effects of the operation. But the surgeon is not justified in withholding a means of relief, if the only one, and if the patient desires it, merely out of regard to his own reputation for success in operations.*

There are several methods in which lithotomy may be performed, and these may be classified, says Mr. H. Thompson,† under two heads, and seem to have originated in two different sets of ideas. The first is the *lateral* operation, which provides an exit for the stone where there is most space for it, that is, downwards between the coccyx and sacrosciatic ligament. It no doubt comes in the way of important blood-vessels, and it involves free division of the prostate gland.† Hence another class of operations has been devised on anatomical, or *à priori* grounds. They are styled by Mr. Thompson *central* operations, inasmuch as the incisions "are limited to the central part of the perinæum, and are made in the line of the raphe itself or transverse to it, and lie mainly between the anus and the symphysis pubis. They do not approach the rami or the great vessels, nor do they run transversely near to the origin of the branches from the pudic artery. In no case do the incisions reach the external limits of the prostate gland."

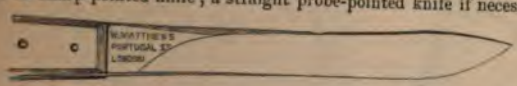
I. The LATERAL OPERATION is doubtless the safest if one opera-

* The mortality from this operation increases as the age does. Out of one hundred and eighty-six cases, collected by Mr. Hutchinson, one hundred and thirty-seven were under the age of twenty, and of these one hundred and twenty-three recovered; forty-nine were over twenty years, and of these no fewer than twenty-six died, or more than half. See Med. Times and Gaz. Jan. 8th, 1859.

† Practical Lithotomy and Lithotrity, or an Inquiry into the best modes of removing Stone from the Bladder, by Henry Thompson, F.R.C.S., Lond., 1863. A book which is really a model for style, method, and practical insight.

tion be applied indiscriminately to all cases. There are an infinity of minute variations in the manner of performing it, and in the instruments employed by different surgeons. In the following pages the author proposes to describe chiefly the method employed by Mr. Fergusson, which he has had many opportunities of witnessing at the King's College Hospital.

1. Lateral Operation.—The instruments needed are the following: A sharp-pointed knife; a straight probe-pointed knife if necessary



to enlarge the internal incision; a curved staff, deeply grooved;—it should be large, the groove deep and not extending more than half way

up the straight part of the instrument;—Mr. Fergusson's staff has the groove on the left side;—forceps of various sizes, and scoops for extract-

ing the stone; and a sound to make sure that the bladder is empty after the operation. Needles and tenaculæ, canulæ and a stone-crusher, may be at hand, in case of need.

The bladder may contain a *little* urine—as much as would collect in an hour.* The best operators prefer it empty rather than full, and do not inject it if empty, as was formerly taught. If the bladder be empty the stone will be close to its neck;—if full when cut into, instead of contracting regularly it falls together in folds which may entangle the stone.

It is advisable that the bowels should be cleared in the morning with a simple enema.

The surgeon must take care that there is a good firm table for the operation; about two feet and a half high. When the time is come, the patient should lie down on this, and be put under the influence of chloroform. Then the staff may be introduced, and should be made to act as a sound, to make clear the existence of the stone to the operator and his assistants. If the staff does not serve this purpose, a sound must be used; for this is a point about which there should be no mistake.

The next point is to place the patient in a convenient posture. He was formerly placed on his back, with his shoulders resting in the lap

* See Thompson, op. cit.

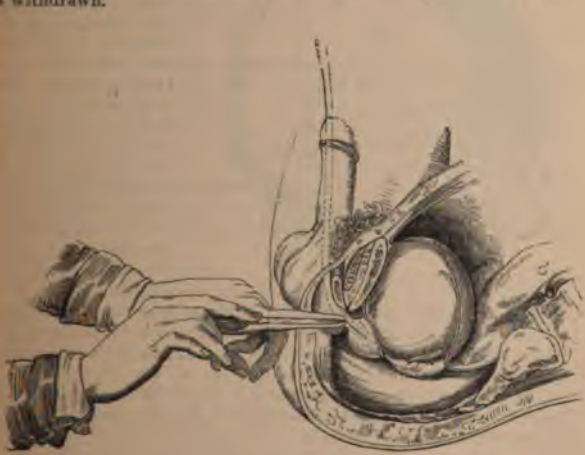
of an assistant, who sat astride behind him. This is dispensed with in these chloroform days, and the shoulders are raised comfortably by a pillow. Then, in order to expose the perinæum thoroughly, he must be made to raise and separate his thighs; and to grasp the outside of each foot with the hand of the same side; and the hand and foot may be firmly bound together by a broad garter. Mr. Prichard, of Bristol, employs a kind of anklet and bracelet, which are buckled round wrist and ankle respectively, and can be securely hooked together or unhooked in an instant. This is preferred by Mr. Thompson. The buttocks should be brought to the edge of the table; meanwhile, if not done before, the perinæum should be shaved. The surgeon may, says Mr. Fergusson, pass his left forefinger well oiled into the rectum, to ascertain the size of the prostate, and its depth from the surface; he should also explore with his fingers the surface of the perinæum, and the position of the rami and tuberosities of the ischia. This exploration, says Mr. Thompson, also makes the rectum contract to the smallest bulk.

Everything being now prepared, an assistant on each side holding the thighs firmly asunder—another being at hand to give the surgeon his instruments—and a fourth stationed on the left side holding the staff perpendicularly, and well hooked against the symphysis pubis—in which position he is to hold it steadily from first to last;—and keeping up the scrotum out of the way;—the surgeon places the fingers of the left hand on the right buttock, and with the thumb fixes the integuments of the perinæum, taking care, however, not to draw them up. Then he commences by a free division of the skin, with more or less of the subjacent tissues; entering his knife just on the left side of the raphe, about an inch and three quarters in front of the anus, and cutting downwards, with a sawing motion, to midway between the anus and the tuberosity of the left ischium. "The blade of the knife," says Mr. Fergusson, "should next be run along the surface of the exposed fat and cellular tissue, and then the forefinger of the left hand be thrust into the wound, about its middle, and directed upwards and forwards between the left erector and accelerator muscles." If any muscular fibres of the transversus or other tissue offers resistance, it may be divided by a touch with the knife; but usually they give way before the finger, which reaches and feels the groove of the staff in the

membranous part of the urethra. This is the first stage of the operation.

The left forefinger nail is now to be well fixed in the groove of the staff, the knife is slipped in over it, with its flat surface nearly horizontal; its point is made to pierce the tissues covering the staff and to enter the groove, and to slide along the groove towards the bladder, dividing the membranous part of the urethra, and the edge of the prostate. This completes what the French would call the second *temps*.

Now the knife being withdrawn, the left forefinger is gently insinuated along the staff into the bladder with a rotatory kind of motion, dilating the parts as it enters; and is made to feel for the stone. "By it, too," says Mr. Thompson, "the surgeon takes a kind of hold of the bladder and maintains his communication with it." In the next place, the assistant removes the staff, and the surgeon cautiously introduces the forceps over the finger into the bladder; the finger being withdrawn as the instrument enters. And, at this moment, Mr. Fergusson, with admirable dexterity, opens the forceps, and with a turn of the wrist, giving a *scooping* motion to the open blades, catches the stone as it is brought within their jaws by the gush of urine that escapes. For it must be observed, that so closely does the finger follow the knife into the bladder, that no urine escapes till the finger is withdrawn.



If, however, the stone is not caught in this ready way, the forceps must be closed and brought into contact with it—then the blades be

opened over it and made to grasp it; if seized awkwardly, it is relinquished and seized again—then it is extracted by slow, cautious, undulating movements. The forceps should be held with the convexity of one blade upwards and of the other downwards; and the endeavour should be to make the parts gradually yield and dilate, not to tear them.

The *general maxims* to be borne in mind during the performance of this operation are, 1, to make a free external incision, and to bring it low enough down, so that the urine may subsequently escape freely without infiltrating the cellular tissue; 2, not to cut deeply too high up, nor to open the urethra too much in front, for fear of dividing too much of the urethra, and wounding the artery of the bulb. Many surgeons begin *one* inch above the anus; 3, not to wound the rectum, or pudic artery, by carrying the incisions too low, or cutting too much inwards or outwards;—the left forefinger should protect the rectum throughout; 4, not to cut *through* the prostate.

It will be noticed that after the first incision, the use of the knife is very limited indeed. Yet, if the stone is very large, the prostate very hard, or if any muscular or other tissues resist the finger as it passes in, they may be touched with the edge of the blunt-pointed bistoury. In fact, the right side of the gland may be divided, equally with the left. Also after the stone has been grasped, the same may be done if needful.

Mr. H. Thompson believes that *infiltration of urine* through too large an internal incision, is not so much to be dreaded as the bruising, and tearing of the neck of the bladder, and its delicate cellular connections which may accompany too small an incision.

The usual *pons* of young operators, is the difficulty of getting the finger and forceps into the bladder, and the propensity to let them slip between the bladder and rectum.

* This diagram, copied from a paper by Mr. Bryant, Lancet, Feb. 11th, 1843, is useful as exhibiting an internal view of the parts at the neck of the bladder, concerned in lithotomy; *a a*, vasa deferentia; *b*, vesiculæ seminales; *c*, prostate; *d d*, ureters.

This, as Mr. Fergusson pointed out in his late lectures at the Royal College of Surgeons, is particularly liable to be the case with children in whom the bladder is more an abdominal than a pelvic organ. The operator does not get into the bladder. Instead of insinuating his finger *through* a wound in the prostate, and *between* it and the staff, he pushes the prostate *before* him, and tears it from the membranous part of the urethra.

In seizing the stone, if not caught at the first gush of urine, care must be taken not to grip the bladder with it. The forceps should have long blades, curved so as to retain the stone without undue pressure. They may be lined with linen, which affords a firmer hold, and takes up less room, and is less likely to crush the stone than the metallic teeth usually employed.

The extraction of the stone resembles a problem in midwifery. As the os uteri must not be allowed to come down before the child's head and get jammed between it and the pubes, so the surgeon must not drag down the prostate in front of the stone, and jam it against the ramus of the ischium. It may be useful, says Mr. Fergusson, to push it back over the forceps with the left forefinger. Moreover, the extracting force must be directed downwards and backwards where the interval between the bones is the largest; and, as Mr. Thompson well observes, should be employed slowly and tenderly to stretch but not to tear.

If the stone is so large that it will not pass, there is the choice of crushing it, by a huge lithotrite, or by a screw instrument invented by Haynes Walton. Large stones are dangerous on account of the manipulation required to extract or crush, and the high operation is proposed for such cases. A surgeon in America finding himself unable to extract a stone by the perinæum, immediately cut into the bladder above the pubes, and extracted it that way. The patient recovered.

If the stone is adherent, or encysted, the finger-nail and the scoop must be employed to detach it. If pouched behind the prostate, a finger in the rectum may lift it within reach of the forceps. If grasped by the bladder behind the pubes it may be brought down by injecting with warm water.

The *varieties of this operation* before alluded to are as follow.

Many surgeons direct the assistant to hold the staff so that it may project in the perinæum, and incline a little to the left side of it,—and when they have opened the urethra, and are about to incise the neck of the bladder, they take its handle in their own left hand, and bring it down horizontally. *Mr. Key* preferred a straight staff. Again, there are great diversities in the manner of cutting into the bladder. Some use a *bistouri caché*, an instrument containing a blade that protrudes to a certain extent on touching a spring. *Sir B. Brodie* preferred a *beaked knife*; or, if the stone is very large, a double-edged knife with a beak in the centre, so as to divide both sides of the prostate. When the bladder is opened he directs the wound to be dilated by means of the *blunt gorget*, which distends the neck of the bladder, and splits cleanly through the prostate, without any risk of hæmorrhage or mischief. Many surgeons open the bladder by means of the *cutting gorget*; the beak of which being put into the groove of the staff, held horizontally in the operator's left hand, is pushed cautiously on, and made to cut its way into the bladder. If this instrument is employed, every precaution must be used to keep it in contact with the staff, and not to let it slip between the bladder and rectum—an accident that has been the death of not a few. *Professor Buchanan, of Glasgow*, employs a rectangular staff, with the shorter branch grooved in its side. This is introduced and made to feel the stone. The surgeon introduces the left forefinger into the rectum (where he keeps it during the whole operation), feels that the prostate is between his finger and the short branch of the sound, keeps the angle of the staff just in front of the gland, and depresses the handle, so that the angle may project in the perinæum between the anus and bulb, and that the left thumb may feel the groove. The handle is now committed to an assistant, with instructions to depress it steadily, and keep it in the same position. The surgeon then plunges a bistoury into the groove of the staff in the middle line just above the anus, at the point where the skin and mucous membrane meet. The bistoury (a straight and sharp backed instrument whose blade, cutting on both edges near the point, and is of the same length as the short branch of the staff) is pushed to the extremity of the groove, being kept strictly at right angles to the handle of the staff. In withdrawing it, it is made to cut at first outwards and downwards, then directly downwards, so that the incision turns as it were round the finger in the rectum. The advantages of this operation are said to be, that it is simple and easy; that it is free from hæmorrhage, because removed from the transverse vessels of the perinæum; and that the incisions are small, and yet the wound roomy, from the extensibility of the rectum.

Buchanan's staff has been modified by Mr. Hutchinson, who has converted it into a grooved catheter staff, with a stopcock; so that the surgeon may be certified, by the escape of urine, that he has really reached the bladder, and may inject water if need be. Dr. Corbett has added to Buchanan's staff another external staff, the short branch of which is pointed; and which is so contrived that when the first staff

is introduced into the bladder, the second external staff is fitted in; its short branch perforates the skin and falls into the groove of the short limb of the first staff, and so the road from the skin into the bladder is unmistakable.* The late *Mr. Avery* constructed a most ingenious instrument, by means of which a baby might perform lithotomy. A staff introduced into the bladder contained machinery, so that by turning a handle, a trocar was made to pierce the perinæum from within; thus making it impossible to miss the bladder. This will come into use when female surgeons cut for the stone.

After-Treatment.—The surgeon—especially if the stone has been crushed, or if there is reason to suspect more than one—makes certain by means of the sound, or by syringing the bladder, that every fragment has been removed. Mr. Fergusson introduces a suppository of morphia, before the patient is removed to his bed. The patient should lie on his back with his shoulders elevated; a napkin should be applied to the perinæum to soak up the urine, and the bed be protected by oilcloth. Some surgeons introduce a large gum elastic canula through the wound into the bladder for it to flow through for the first twenty-four hours. If not, the surgeon should introduce his finger after a few hours, to clear the wound of coagula. Pain must be allayed by opium—the bowels be kept open with castor-oil—the wound be kept perfectly clean—the diet be nourishing—and then, in favourable cases, the urine begins to flow by the urethra in about one week (sometimes in three or four days), and the wound heals completely in four or five.

Complications.—1. Severe *hæmorrhage* may proceed at the time of the operation, or after it, from the pudic, prostatic, or bulbous arteries if wounded. If the bleeding orifice cannot be secured, it must be compressed as long as may be necessary with the finger. A general venous or arterial oozing must be checked by filling the wound firmly with lint or sponge—the tube being then indispensable; and by ice applied to the perinæum, or lower part of the abdomen. Care should be taken that blood does not accumulate in the bladder. This may be suspected if the patient is pale and exhausted, and must be combated by injections of cold water, to make the bladder contract. Sloughing of the areolar tissue, a result of a hasty operation, is indicated by heat and pain about the neck of the bladder; heat of the skin and sleepiness, followed by a rapid jerking intermittent pulse—hiccup—the belly tympanitic, the countenance anxious, and the other signs of irritative or typhoid fever. To be treated by hip-baths, wine and bark, thoroughly opening the wound with the finger, and, if necessary, laying the wound into the rectum, so that the urine and fetid discharge may escape. 3. *Simple peritonitis*; pain and tenderness extending from the bladder over the abdomen, must be treated as directed at p. 545. 4. *Pyæmia*, see p. 64.

II. CENTRAL LITHOTOMY.—The bilateral operation is performed by making a curved incision, with the convexity upwards, from

* See Hutchinson's paper, Med. Times and Gaz., Feb. 21st, 1857; and Corbett th., Dec. 8th, 1858.

one side of the perinæum to the other—carrying it between the anus and bulb of the urethra—opening the membranous portion of the urethra—and then pushing a double *bistouri caché* into the bladder, by which both sides of the prostate may be divided.

Some years since Dr. Willis proposed an operation, which he called LITHECTASY, or CYSTECTASY, in which, after the membranous part of the urethra was laid open, the prostate was dilated by fluid pressure, till it admitted of a forceps being introduced to seize the stone. The success of this operation in the six or eight cases in which it was tried, was not great—probably because the patient was kept too long under treatment.*

ALLARTON'S OPERATION.—An operation on the same principle has been proposed by Mr. Allarton.† A staff with a central groove is introduced, and held firmly against the pubes. The operator having introduced his left forefinger into the anus, and pressing its point against the staff in the prostate, passes a long-handled straight-pointed knife into the perinæum, exactly in the middle line, about half an inch above the anus, till it hits the groove in the staff. Then he moves the point of the knife a few lines towards the bladder, and next withdraws it, enlarging the incision upwards as he does so, to the extent of from three-quarters of an inch to an inch and a half. Next, he passes a long ball-pointed wire or probe along the groove of the staff quite into the bladder, and withdraws the staff. Following the guidance of the wire, the operator insinuates his left forefinger, well greased, along it through the prostate, dilating the parts as it goes onwards. Now if the stone is small, it probably comes in contact with the finger; and if the patient strains, will follow the finger as it is withdrawn, and come out. If not, the wound in the prostate may be further dilated by Weiss's female dilator, or by the end of the forefinger enlarged by the superimposition of several india-rubber finger-stalls. In cases of difficulty, the stone may be crushed, or the operation converted into the common bilateral one. Amongst the advantages of this operation, Mr. Allarton enumerates the impossibility of missing the bladder; the small amount of cutting, and of danger; and the fact that the patient, from the wound being in the middle line, preserves the power of the muscles, and can strain so as easily to bring the stone within the reach of the operator. This operation, says Mr. Thompson, is that by which the bladder is reached with the smallest amount of cutting. "It appears to become dangerous, just in proportion as injury by laceration or over-pressure under the name of dilatation is superadded to the incisions." Want of space is the vice of median operations; they are therefore not adapted for children, nor for large stones, nor for large and rigid prostates; and it is better to incise either side, than use undue force in dilatation.

JOHN WOOD'S OPERATION.—Mr. Wood, after a limited incision round the front and left side of the anus, opens the membranous

* See Willis on the Urinary Organs; Ranking's Abstract, vol. iii., p. 119.

† Lithotomy Simplified, by G. Allarton, Lond., 1854; A Treatise on Modern Median Lithotomy, Lond., 1863.

urethra up to the prostate. Then comes into play the peculiar staff of his invention, the blades of the grooved portion of which can be separated in the prostate, so as to stretch the passage and allow the surgeon's left forefinger to be gradually insinuated into the bladder. The incisions are limited, the vessels safe, and the operator *cannot* miss his road nor push his finger in any wrong direction.

The writer will say, in conclusion, that the general history of medicine and surgery is in favour of such methods as spring from experience, rather than from *à priori* considerations.

III. THE RECTOVESICAL OPERATION consists in cutting into the bladder from the rectum, in the middle line behind the prostate. M. Chassaignac has twice performed a recto-vesical lithotomy in the middle line, by means of the *écraseur*.*

IV. THE HIGH OPERATION is performed by making an incision through the linea alba, and opening the bladder (which is projected upwards on the point of a long catheter) at its fore and upper part, where it is not covered by peritonæum. This operation may be occasionally resorted to when the stone is of great size, and the prostate much enlarged, or the space between the tuberosities of the ischia contracted.

SECTION XV.—STONE IN WOMEN.

STONE IN WOMEN is much less frequent than it is in men, and when a renal calculus reaches the bladder, it is much more easily voided. If, however, there be one too large to escape, it must be removed.

1. The surgeon may employ *lithotrity*.

2. The orifice of the urethra may be simply dilated, which may be effected by *Weiss's female dilator*, slowly or quickly, as may be desired.

3. Not to mention the plans for cutting into the bladder from the vagina, or other parts, the orifice may be incised.

4. Incision may be combined with dilatation.

The great evil is the almost certainty that more or less incontinence of urine will follow. Mr. Fergusson recommends that the dilatation should be effected very slowly, by means of a metallic or some other dilator, till the urethra is capable of admitting the forefinger, when a forceps may be introduced to seize the stone. If this should not answer, and it seems necessary to make an incision, he recommends that the anterior half of the urethra—not its whole length into the bladder—should be divided to the extent of half an inch with a probe-pointed bistoury; after which sufficient dilatation may be effected with the forefinger oiled. The outer part of the urethra, which is the most undilatable part of it, would be alone divided by this operation, and the neck of the bladder, unless very roughly used, would speedily acquire its tone and use. In this way the eminent surgeon just quoted has extracted a stone three inches in circumference, and the patient had the power of retaining her urine immediately afterwards.†

* De la taille Recto-Vésicale par écrasement linéaire, par Emile Servoin, D.M., &c. &c. Paris, Rignoux. 1862.

† Fergusson, Practical Surgery, second edition, p. 135.

CHAPTER XXI.

DISEASES OF THE MALE GENITALS.

SECTION I.—DISEASES OF THE PENIS.

I. PHYMOSIS signifies a preternatural constriction of the orifice of the foreskin, so that the glans cannot be uncovered without difficulty, if at all. It may be a congenital affection, or may be caused by the contracted cicatrices of ulcers. Besides the obstruction which it occasions to the functions of the organ, it prevents the washing away of the secretions from the corona glandis, and thus renders the patient liable to frequent *balanitis* and gleets, and in advanced age to epithelioma of the penis; and it is a source of great trouble if he happen to be affected with the venereal disease.

*Treatment.**—The surgeon may either *circumcise*, that is, cut off the end of the foreskin, which is advisable if the end is thickened and gristly, or may slit it up. If he circumcises, he should draw out the end of the foreskin, hold it between the blades of forceps, and cut it straight off; after which, with scissors, he should cut up the mucous lining of the foreskin to the corona, so as quite to uncover the glans. If he prefers the slitting plan, a director may be introduced about an inch between the glans and prepuce, and a curved, narrow-pointed bistoury passed along its groove, by which the prepuce may be slit up. Then, in the adult, after either operation, four or five fine sutures should be passed through the margin of the incision, so as to draw together the edge of the skin and that of the mucous lining of the prepuce, that they may unite by adhesion. If this is not done, the skin and mucous membrane will be separated by the swelling and occasional erection that follows the operation, and the wound, instead of being a mere line, will be half an inch wide. In a young child, these sutures, however, may be dispensed with without disadvantage, the operation being rendered much shorter and less painful. Instead of these operations it is now proposed to make two or three cuts, each about a quarter of an inch deep, through the skin and mucous membrane

* The author early this year saw a Cambridge student, æt. 23, affected with congenital phymosis of the tightest kind. He advised him to come up to town in the long vacation to be circumcised; and meanwhile, for the sake of cleanliness, daily to inject warm water under the prepuce. The result was that the orifice spontaneously gave way, and no operation was required.

forming the edge of the prepuce, at equal distances. But the author has seen unsatisfactory results from stingy operations.

II. PARAPHYMOSIS is said to exist when a tight prepuce is pulled back over the glans, constricting it, and causing it to swell.

Treatment.—The surgeon first compresses the glans, well oiled and covered with a bit of lint, in the fingers of one hand, so as to squeeze the blood out of it, then pushes it back with that hand, whilst he draws the prepuce forwards with the other. If this fails, the constricting part of the prepuce must be divided with a curved-pointed bistoury.

III. CANCER OF THE PENIS is rare. That which is commonly called cancer, is epithelioma, which generally begins as a warty excrescence on the inner surface of the prepuce. It generally occurs to elderly persons, who have had phymosis. The disease, left to itself, follows the ordinary course. After a time ulceration commences. Whilst one part is perishing, fresh warty growths sprout up and invade the rest of the organ; ulceration spreads with its fetid discharge; there is immense irritation with the urine; the morbid growths strike root into the corpora spongiosa; the glands in the groin are affected, and the patient dies miserably.

This disease may be combined with cancer; it may be complicated with syphilis; it may, in its earlier stages, be identical with, or indistinguishable from, vascular warts, or condyloma, if ulcerated. The rule hence deducible is, that free and early extirpation should be performed in all doubtful cases of papillary excrescences, and that if the disease return, the part should be amputated. Statistical results are here impossible without microscopic examination; but the general experience of surgeons may be expressed by the words of Fergusson: "that if certain sores which may be termed pseudo-cancerous were treated by excision at an early date, there would be a better result than surgery can yet boast of;" but that when the disease has obtained a firm footing, a temporary respite is all that amputation can give.

IV. AMPUTATION OF THE PENIS.—An assistant steadies and compresses the root of the organ; then the surgeon stretches it out with one hand, and cuts it off with one sweep of a bistoury. Care must be taken that too much of the skin of the prepuce is not left, as it constitutes an impediment to the passage of the urine afterwards. It is better also to slope off the incisions opposite to the urethral canal so as to leave the spongy body a little longer than the cavernous, with a spout-like end. The urethral wall should then be slit up a little way, and the mucous membrane stitched back to the preputial skin, so as to counteract the tendency to contraction which the opening of the urethra always shows after this operation. Bleeding vessels are now to be tied, and cold to be applied, and after three or four days a piece of bougie is to be introduced into the orifice of the urethra, and to be retained there during the cicatrization.

V. EPISPADIAS.—As the hæmapophyses of the foremost vertebra in the cranium and the soft parts covering them, may be ill developed,

leaving the fissures known as cleft-palate and hare-lip, so the corresponding parts of the sacral series, if ill developed, leave fissure, in that region. 1. The pubic bones may be imperfect at the symphysis, leaving a gap, completed by ligament. 2. The two sides of the penis may be separated—which the surgeon may attempt to unite, but will hardly succeed. 3. There may be complete absence of the anterior wall of the bladder, the abdominal wall, the pubic symphysis, and of the upper surface of the penis. This is a horrid case: there is a deep gap at the lower part of the abdomen, from which the red mucous membrane of the bladder protrudes, and the urine is incessantly dribbling. The testicles and scrotum may be well developed. The surgeon may content himself with mechanical appliances for palliating the patient's inconveniences; or he may attempt, if he thinks it prudent, a radical cure, such as that which Mr. Simon devised and executed. This consists in first establishing a fistulous passage from the imperfect bladder into the rectum, and then in closing the edges of the fissure. The results of the operation were not proportionate to the ingenuity and skill evidenced in its invention and execution, as the patients eventually died.* Mr. Wood has recently operated on two of these cases with complete success. This surgeon does not attempt to open the bladder into the rectum, but closes the gap in the abdominal wall by transplantation from the groin and scrotum, leaving a small opening above the imperfect penis to act as an urethra, to which an india-rubber bottle can be fixed. Mr. Holmes, of St. George' Hospital, has also succeeded in a like operation in two cases out of four.

VI. HYPOSPADIAS is a deficiency of the parts constituting the under surface of the urethra. It is very common indeed for the last half inch or inch of the urethra to be impervious, there being an orifice about the situation of the frænum; but this requires no treatment. If the gap is so extensive as to interfere with the proper use of the genitals, it may be attempted to be relieved by paring the edges of the skin on each side of the fissure, and uniting it by suture, provided that the urethra is pervious to the end of the penis. An American surgeon has proposed to unite the edges of the fissure by cauterizing them with nitrate of silver, and then scraping off the black eschar; by which means the surfaces are made raw without hæmorrhage or loss of substance.

VII. ELEPHANTIASIS.—The natives of India are liable to this disease in the areolar tissue of the penis and scrotum, which parts become completely buried in the enormous tumours which are developed, and which may weigh possibly 60lb. to 180lb., hanging down to the patient's knees, or even to the ankles. (See p. 683.)

The malady generally begins in the prepuce, from which it spreads and involves the areolar tissue of the scrotum. The skin is wrinkled, and there is a kind of aperture from which the urine escapes. The

* Mr. Simon's case, Lancet, 1852, vol. ii., p. 568; case by Mr. Lloyd, Lancet, 1851, vol. ii., p. 370.

only remedy is extirpation of the diseased mass, which should be done early. There can be no danger in trimming off a *few* pounds of redundant scrotum. But if the disease be very voluminous (following the directions of Allan Webb and other Indian surgeons, and of Dr. Wiblin, by whom the author saw a remarkable scrotal tumour removed at Southampton in 1862), the surgeon should place the patient on a table, two hours before the operation, should raise the tumour by a pulley attached to the ceiling, and should ice it, so as to let all possible blood return from it into the circulation. Chloroform is given; a clamp composed of parallel bars, with screws at each end, is applied to the neck of the tumour to act as a tourniquet; if there be any hernia, care should be taken that it has been *wholly* reduced. Then he makes first a longitudinal cut with a long knife up the urinary aperture, over the dorsum of the penis, which part is to be dissected out; next, by similar incisions over each cord and testicle, those parts are exposed, dissected out, and held up: whilst lastly the operator makes a clean sweep with the remainder of the tumour. The great danger is the hæmorrhage; which must be obviated by a rapid operation, and by plenty of ligatures.

If the tumour is very large, the attempt to save the testicles, or even the penis, might be hazardous, and a clean sweep must be made.*

SECTION II.—DISEASES OF THE TESTIS.

I. ACUTE INFLAMMATION of the testis (*acute testitis, orchitis, hernia humoralis*) may be caused by local violence, but more frequently occurs in conjunction with gonorrhœa, through an extension of inflammation from the urethra. It is very liable to be induced if the patient indulges in violent exercise and fermented liquors, or neglects to use a suspensory bandage while employing injections.

Symptoms.—The discharge from the urethra diminishes, and the patient soon complains of aching pain in the testis and cord, extending up to the loins, and soon followed by great swelling, excruciating tenderness, fever, and vomiting. The epididymis is the part most affected. The swelling depends mainly upon an effusion of lymph and serum into the tunica vaginalis.

Treatment.—Absolute rest in bed; the application of leeches, or the abstraction of blood from some of the veins of the scrotum; opium at night to allay pain; purgatives, especially F. 40, followed by tartar emetic in doses of a sixth of a grain, F. 67, every five or six hours, warm fomentations, and a suspensory bandage, or handkerchief, to elevate the part upon the abdomen. After the acute stage has subsided, strong astringent lotions, F. 117, may be employed. Some hardness and swelling (as the patient should be informed) always remain after the acute attack. As soon as the very acute stage has subsided, *com-*

* Field Notes for Amputations, &c., by Allan Webb, M.D., Calcutta, 1855. East Indian cases; Esdaile on Natural and Mesmeric Clairvoyance, Lond., 1852. John Wiblin's case, Med. Chir. Trans. vol. xlvi., and Med. Times, 1862, vol. ii., with tabular *record of European* and West Indian cases.

pression will be found a useful means of reducing the swelling, and supporting the dilated vessels. The affected testicle is grasped and separated from its fellow, and then is encircled with strips of adhesive plaster, which are to be applied regularly and as tightly as the patient can bear; the first strap being applied round the spermatic cord immediately above the testicle, and the other downwards in succession, slightly overlapping each other.*

Acute inflammation of the testicle is treated by Mr. Henry Smith by simply making a deep puncture with a thin sharp knife into the body of the testis. By this incision a small quantity of serum and a few drachms of blood are emitted, and almost instantaneous relief is given to the pain. Scarcely any other means beyond a little aperient medicine, or the use of a cooling lotion are employed. Mr. Smith is of opinion that the efficacy of this plan of treatment is due mainly to the tension being taken off, the compressed tubes of this testicle through the free division of the tunica albuginea, although some amount of relief must result from the direct removal of blood from this inflamed part.

II. CHRONIC INFLAMMATION (*Sarcocele*) is known by more or less hardness, swelling, tenderness, and occasional pain. Very often it commences in the epididymis. It may be a sequel of acute inflammation, or may be caused by disease in the urethra, which should always be looked for, and treated if found. It sometimes depends on a syphilitic taint, which will be probable, if the patient has the aspect of secondary syphilis, if the pain is principally severe at night, and if there are secondary venereal affections of other parts: chronic rheumatism is often a cause. It very often, in its latter stages, is accompanied with some degree of effusion into the tunica vaginalis (*hydro-sarcocele*). It may be distinguished from cancer by the distinction between testis and epididymis not being lost; by its often affecting both testes; by the greater uniformity and smoothness of the swelling, its slower progress, and less amount of pain and superficial vascularity. As it increases, the tumour softens in parts, thus again presenting similarity to cancer; but when it softens it is not so large as soft cancer would be. On examination, the testicle is found to contain a yellow exudation, which is both interspersed in its substance, and also, according to Sir B. Brodie and Mr. Curling, is deposited in the tubuli seminiferi, and may be found extending into the vas deferens.

Treatment.—So far as regards the part—rest; a suspensory bandage; occasional leeching; or cold lotion; or iodine paint; or blisters; or Scott's ointment, with pressure by strips of plaster. The constitutional treatment requires care and discrimination. In some uncomplicated, and in some syphilitic cases, it is expedient to administer mercury very gently; in other cases, corrosive sublimate with bark or

* This practice, which was first recommended by Fricke, of Hamburg, was adopted by Ricord, and introduced into this country by Mr. Acton and Mr. Langston Parker. See also T. Blizard Curling on Diseases of the Testis, 2nd edit., Lond., 1856; Cæsar Hawkins, Lond. Med. Gaz., N.S., vol. iv., p. 943.

arilla, the iodide of potassium, cod-liver oil, nourishing diet, and

. ABSCESS of the testis may be a result of chronic or scrofulous mation—very rarely of the acute. A puncture should be made n as fluctuation is clearly felt, and the skin is adherent. And the matter has been evacuated, the case should be treated by ire, and in other respects like any other abscess.

. FUNGUS, or HERNIA TESTIS.—When the fibrous tissue of the has been perforated by abscess, a soft fungus, composed of the i, and of fibro-plastic matter, is apt to protrude. This should be ied to its place by pressure with lint and strips of plaster; bi- de of mercury or iodide of potassium with tonics may be given cite absorption of interstitial lymph if there is a syphilitic or ilous taint; and stimulating applications, such as the lunar caustic, d be used in order to excite granulation. Should this fail, Mr. 's operation should be resorted to, of making two semi-elliptical ons ( ), one on either side of the fungus, removing the narrow of skin around the fungus, and then bringing the healthy skin either side over it, and employing sutures and other measures for ring adhesion. To shave off the protruding substance would be equal to castration.

SCROFULOUS INFLAMMATION commences with a deposit of so called "cle" into some part of the testis or epididymis, either into or be- the tubuli. A nodular swelling appears externally, attended ery little pain or tenderness, which after a time inflames and and gives exit to the fungous protrusion just mentioned. It ppens that the lungs are diseased as well. *Treatment.*— lth must be invigorated by cod-liver oil, bark, the iodides of potassium, lotions of zinc, iodine, &c. (See p. 96.) When ibercular matter has been evacuated, the abscess heals of itself; e this occurs, the whole organ is often disorganized and ren- less, and sometimes it is necessary to remove it, on account of ion and drain on the system.

ROPHY of the testicle may be a result of excessive venereal , or of injury or of inflammation; the part becoming filled ation, which degenerates, and in so doing annihilates the ucture, and is then itself absorbed. The gland may dwindle of a pea. There is no cure.

ERFECT DESCENT OF THE TESTICLE.—This organ may n in the abdomen permanently, or may be stopped in the al. The latter condition renders it extremely subject to ury, and renders the patient liable to hernia. In order to e evils, Mr. Curling recommends, that if the testis has the abdomen by the time the child is a year old, a truss plied to prevent it from coming down at all. When a lly come down, is complicated with hernia, an endeavour to keep up the hernia by a small pad, which will keep n. In cases, in which the testicle in this situation is

mistaken for hernia, the absence of it from the scrotum, the peculiar pain felt on handling it, the peculiar consistence of the swelling, and the absence of impulse on coughing, are the chief diagnostic marks.* (See p. 570.) In these cases, Mr. Wood recommends the use of a truss with a perforated or ring pad covered by a water cushion of india-rubber. The opening in the pad is to be made large enough to receive the projecting testicle, while the edges of the ring protect it from injury, and restrain the protrusion of the hernia behind the testicle. (See Wood on Rupture.)

VIII. NEURALGIA of the testis and cord produces fits of excruciating pain, which leave the parts tender and slightly swollen. The *treatment* must be that of neuralgia generally. (See p. 20.) Violent purgatives in general do mischief. A few leeches, the application of intense cold, counter-irritants, and opiate or belladonna plasters or liniments, sometimes afford relief. The internal remedies most likely to do good are steel, quinine, and other tonics. Extreme sensitiveness of the testis, so that it cannot bear the slightest touch—the representative of the irritable uterus and ovaries—is another form of this disorder sometimes met with in nervous hypochondriacal subjects; especially in persons who labour under a diseased condition of the urethra, or excessive spermatic discharges. Tonics and cold applications may be tried, and the cause of the affection should be ascertained, and, if possible, removed. In these cases the patients often desire to be castrated. But the surgeon is not justified in doing so, unless there is positive disease. For a surgeon to remove healthy testicles for epilepsy, or neuralgia, or monomania, is an abominable act, which deserves to be punished according to the Mosaic law, "An eye for an eye, and a tooth for a tooth."

IX. HYDROCELE signifies a collection of serum in the tunica vaginalis.

Symptoms.—It forms a pear-shaped swelling, smooth on its surface, fluctuating if pressed, free from pain and tenderness, causing merely a little uneasiness by its weight. It commences in the lower part of the scrotum and grows upwards. Occasionally, if large, it is constricted obliquely across the centre by a band of fascia. The epididymis and testicle can sometimes be felt on the posterior surface of the tumour near the bottom. On placing a lighted candle on one side of the scrotum, the light can be discerned through it.

Causes.—Hydrocele may be a sequel of inflammation of the testis or of syphilis, but more frequently arises without any local cause. It is often supposed to follow strains of the loins or belly.

Diagnosis.—Solid enlargements of the testis may be distinguished from hydrocele by their weight, solidity, and greater painfulness, and by the absence of fluctuation or transparency. The diagnosis from hernia will be found at p. 568.

Varieties.—It sometimes happens that the tunica vaginalis preserves its communication with the abdomen, and then becomes filled with

* See T. Blizard Curling, op. cit., 2nd edit., 1856.

serum, forming a cylindrical tumour, extending up to the abdominal ring, to which the name *congenital hydrocele* is applied. On raising and compressing it, the fluid is slowly squeezed into the abdomen, and slowly trickles down again afterwards. This case is liable to be complicated with a *congenital* or *encysted hernia*, to prevent which, and to close the communication with the cavity of the peritonæum, a truss should be worn. Sometimes the transparency and fluctuation of hydrocele are absent in consequence of a thickening of the tunica vaginalis, which may be known, according to Brodie, by noticing that the thickened membrane forms a projection along the epididymis, whereas in solid enlargements of the testicle the projection of the epididymis is lost. Sometimes the tunica vaginalis is partially adherent to the testicle. Sometimes loose cartilages are found in the sac; they are easily removed by a slight incision.

Treatment.—The remedies for hydrocele are threefold. 1. Strong discutient lotions (F. 118, &c.), which sometimes assist the cure in children, but cannot be depended on for adults. 2. Evacuation of the serum, or the *palliative cure*. This may be accomplished by a puncture with a common lancet, or trocar; but the method most commonly adopted at present, consists in making a number of punctures with a grooved needle, so that the fluid may escape from the tunica vaginalis into the cellular tissue of the scrotum, whence it is readily absorbed. This *palliative treatment* is always sufficient for children, but very rarely so in the case of adults.

3. *Radical Cure.*—This is performed by injecting certain stimulating fluids, or by introducing setons or other foreign substances into the tunica vaginalis, in order to excite a degree of inflammation sufficient to destroy its secreting faculty. It must not be forgotten, however, that this *radical cure* is totally inadmissible if the testis is diseased, or if the hydrocele is complicated with an irreducible hernia, or if the tunica vaginalis preserves its communication with the abdomen. Mere thickening from *previous* disease is, however, no objection.

Operation.—The surgeon grasps the tumour behind, and plunges a trocar and canula into the sac, pointing the instrument upwards, so

* Hydrocele. From King's College Museum.

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that it may not wound the testicle. He next withdraws the trocar, at the same time pushing the canula well into the sac. Then, the old plan was to inject three or four ounces of some irritating liquid, such as port wine or zinc lotion, through the canula, by means of an elastic bottle fitted with a stop-cock, to let it remain a few minutes, and then let it run out, and withdraw the canula. But the remedy most in favour at present is the *tincture of iodine*, which was used with very great success at Calcutta, by Sir R. Martin. The disease is so common in the East, that Sir R. Martin can refer to thousands of successful cases. The sac having been punctured with a small trocar and canula, about one or two drachms of a mixture of one part tincture of iodine, and two of water are injected and *allowed to remain in the sac*. Mr. Fergusson uses for this purpose a small glass syringe, with a silver or platinum nozzle made to fit the canula. Mr. Curling recommends palladium. One advantage this method certainly has—namely, that there is much less chance of extravasation into the scrotum, than when the sac is filled with many ounces of fluid. Some amount of pain, inflammation, and effusion may be expected to follow; and when they subside, the part generally secretes no longer. If it does, the operation must be repeated; or one of the older plans, such as a few threads passed through the sac, by way of seton, or an iron wire, as proposed by Dr. Simpson, may be tried.

X. ENCYSTED HYDROCELE.—Sometimes a serous cyst is developed on or near the testis. Most frequently it is situated between the tunica vaginalis and epididymis; very rarely between the tunica vaginalis and testis, and more rarely still within the substance of the external layer of that tunic; sometimes in the spermatic cord. These cysts contain a clear liquid, in which spermatozoa have been found; owing, as Mr. Curling has shown, to accidental rupture of one of the ducts of the gland. They may be punctured with a grooved needle to let the fluid escape, if they have become of inconvenient bulk; and if it is necessary to adopt some radical method of cure, the best plan seems to be to pass a thread or two through the sac with a curved needle, and retain it till it has caused some inflammation.

XI. HÆMATOCELE signifies an extravasation of blood into the tu-

* Encysted hydrocele. From a preparation in Middlesex Hospital Museum.

nica vaginalis, in consequence of injury. It is sometimes combined with ecchymosis of the scrotum.

Treatment.—In the first place, time, rest, moderate purgatives, and cold lotions, must be employed to prevent or allay inflammation, and allow the blood to be absorbed. Should great inflammation and tense swelling threaten suppuration, an incision should be made. But sometimes the long presence of unabsorbed blood leads to more serious ill consequences. A ponderous tumour is formed, consisting of the expanded tunica vaginalis, lined with clot, and filled with sanguinolent serum. If tapped, it probably fills again. For this case, the only thing to be done is to make a free incision, turn out the clot, and leave the cavity to granulate. But if, from the magnitude of the tumour, it is evident that the risk of this operation, and of the sloughing that may follow, is too great—and if, as probably happens, the testicle itself is wasted by the continued compression, and completely involved in the fibrinous layers, so as to be indistinguishable—the only remedy remaining is extirpation.*

XII. VARICOCELE (*Cirsocele* or *Spermatocele*) signifies a varicose state of the veins of the spermatic cord. It is induced by the ordinary causes of varix; that is to say, weakness of structure combined with obstruction to the return of blood through corpulence, constipation, and the like. It is much more common on the left side than on the right; the traditional explanation of which is, that the left spermatic vein is more pressed upon by fæcal accumulations, and that its course is longer and more circuitous than that of the right vein opening at right angles into the renal vein.

Treatment.—In ordinary cases, sufficient relief may be obtained by keeping the bowels thoroughly open; by frequently washing the scrotum with cold water or astringent lotions, so as to constringe the skin; and by supporting it with a suspensory bandage, made of good stout *jean*, braced firmly to a band passing round the pelvis. But there are some cases in which this disease produces very serious inconvenience—pain in the scrotum and loins—sense of dragging at the stomach—loss of appetite—flatulence—and despondency of mind—and for these cases, something more must be done. Mr. Wormald recommends the loose skin of the scrotum to be pinched up and confined with a steel ring. Blisters and counter-irritants, so as to inflame and condense the scrotum; division of the veins by the knife or caustic, and passing setons of thread through them, have had their advocates; and even the barbarous operation of passing a ligature through the scrotum, and tying up the skin of half the scrotum, with all the vessels except the artery and vas deferens—so that they may be divided by ulceration—has been practised in some cases with success; in others with fatal results, but certainly always with a risk of causing atrophy of the testis. A more humane method is that of passing the ligatures subcutaneously, so as to divide veins only and not skin. These opera-

* See case by Bowman, Lancet, 1853, vol. i., p. 177.

tions on the veins are always attended with some risk. This risk, however, is considerably lessened by the use of metallic wire sutures or needles, a combination of which has been before described under the section Varicose Veins, in the operation performed by Mr. Wood (see p. 361). Less suppuration follows their use in the above manner. There is, therefore, less danger of pyæmia. Sir A. Cooper proposed the operation of cutting away a good piece of the loose relaxed skin. "The manner of performing it is as follows:—The patient being placed in the recumbent posture, the relaxed scrotum is drawn between the fingers; the testis is to be raised to the ring by an assistant; and then the portion of the scrotum is to be removed by the knife." Any artery requiring it must be tied; and cold must be applied to check bleeding; and then the lower flap of the scrotum must be brought upwards and forwards, and be attached by sutures to the fore and upper part; and a suspensory bag be applied to press the testis upwards, and glue the scrotum to its surface.

One method consists in the application of moderate pressure to the dilated veins at the external abdominal ring, by means of Evans's patent lever truss; so as to release them from the pressure of the superincumbent column of blood, and afford them a moderate degree of support.*

XIII. MORBID GROWTHS.—The testicle is liable to almost every variety of morbid growth. Thus the *fibrous* and fibro-plastic tumours may be developed within it; cysts of various kinds (forming the *hydatid disease* of Sir A. Cooper), of which probably the origin is, according to Mr. Curling, to be found in dilated tubules of the rete testis, and which may accompany cancer, and other growths that are not cancer;—and *enchondroma*, which seems to have a peculiar predilection for the testicle, and may be found here in connexion with many other kinds of morbid growth. It may be developed within the tubules, or within the lymphatics.* The diagnosis of these growths is chiefly concerned in proving, first, that they are not inflammatory nor syphilitic, on the one hand, which is shown by their resisting all treatment; and secondly, that they are not cancerous, which is shown by their slowness of increase, and by the absence of cachexia. If the tumour becomes of unsightly magnitude, it should be extirpated.

XIV. CANCER of the testis is almost always of the soft variety; it may be combined with enchondroma, or with cystic growth. At first the gland swells, and becomes hard, heavy, and elastic in feel; it is scarcely, if at all, painful or tender, and merely causes slight aching in

* See Sir A. Cooper, Guy's Hosp. Rep., vol. iii.; Reynaud, Journ. des Connaissances Méd., Feb. 1839; James in Prov. Med. Trans. for 1840, and Curling, op. cit. The diagnosis of Varicocele has been spoken of at p. 570.

† See Jabez Hogg, Path. Trans., vol. iv.; Curling, Med. Chir. Trans., vol. xxxvi., and Path. Trans., vol. vi.; and especially Mr. Paget's account of a case of enchondroma of the testicle, Med. Chir. Trans., vol. xxxviii. The testis was cut out, and the patient perished of an extension of the disease up to the lumbar glands, into the ascending cava, and throughout both lungs.

e loins by its weight. After a time it enlarges rapidly and feels soft; rge and tortuous vessels appear under the skin; the cord swells, there e occasional darting pains passing up the the cord into the back, with heavy dragging sensation in the gland, the lumbar glands become fected, large tumours form in the iliac fossa, and cachexia and death on follow in the ordinary course.

Treatment.—When the patient first applies, it will be right, if the iagnosis is undecided, to treat the case as if fibro-plastic or syphilitic, y the administration of iodide of potassium. But if the disease is roved to be cancer, and there is as yet no invasion of the lumbar lands, nor marked cachexy, extirpation may afford the patient a few onths of life less burdened by pain and disease.

XV. CASTRATION is performed thus:—the scrotum being shaved, he surgeon grasps it behind to stretch the skin, and makes an incision nto the tunica vaginalis, to examine the testis, if there is any doubt in he diagnosis. If there is none, he extends the cut from the external bdominal ring to the very bottom of the scrotum. If the skin adherent, or diseased, or if the tumour is very large, two elliptical cisions may be made, so as to remove a portion of skin between them. hen he separates the cord from its attachments, and an assistant holds firmly between his finger and thumb, to prevent it from retracting en divided. He now passes his bistoury behind the cord, and di- es it; and seizing the lower portion draws it forward and dis- ts out the testicle. The arteries of the cord, and any others uiring it, are then to be tied; and the wound must not be closed till the bleeding has ceased, as this operation is often followed by ndary hæmorrhage.

SECTION III.—DISEASES OF THE SCROTUM.

ŒDEMA OF THE SCROTUM.—The loose cellular tissue of this is liable to immense distension from dropsy. Punctures with a -needle will relieve it. If great and tense œdema, from erysipelas inflammation, should threaten sloughing, a free incision should le.* The latter case very much resembles extravasation of urine, ay be distinguished by the absence of swelling in the perinæum, obstruction in micturition.

CANCER SCROTI.—This disease is commonly called the *Chim- ey-sweeper's Cancer*, because it is said to be seldom met with except that class of men, and because the irritation of soot is said to use of it. Some other irritants are believed to have the same the scrotum. Thus, it is stated on the authority of Dr. Paris, ters are liable to a similar disease. And on the other hand, it at soot may produce this disease on other parts beside the The etiology and anatomy of the disease, however, require vestigation.

ly commences as a florid vascular wart, called the *soot-wart*.

on Acute Œdema of the Scrotum, Med. Chir. Trans., vol. xxii.

This gradually spreads, affects the whole scrotum and neighbouring parts of the penis, and ulcerates, producing a fungous sore with ragged edges, discharging a thin offensive matter, and causing so much pain and constitutional disturbance as ultimately to destroy life. The superficial inguinal glands become secondarily affected in this form of disease, constituting an important diagnosis between *cancer scroti*, and cancer of the testis itself in which the iliac and lumbar glands are first affected.

This disease is probably, in general, epithelioma, sometimes cancer; in either case, free and early excision should be adopted, as we have often before said.*

SECTION IV.—IMPOTENCE AND SYPHILOPHOBIA.

IMPOTENCE in the male may depend on a variety of conditions. 1. It may be caused by absence, or mutilation, or malformation, or original weakness and want of development of the genital organs. 2. After any severe illness, the genitals may remain incapable of performing their functions, long after the restoration of the health and strength in other respects. Steel and other tonics, with cantharides, musk, nux vomica, Indian hemp, galvanism cautiously applied to the spine, spices, eggs, and oysters, and above all, *time*, and abstinence from attempts at connexion till the strength is fully restored, are the remedies. Phosphorus, F. 191, is said to be a potent *aphrodisiac*. 3. Blows on the head, or spine, are apt to be followed by impotence; which sometimes is relieved, but more frequently is permanent. A cautious course of mercury, followed by the stimulating aphrodisiacs just mentioned, are the remedies most likely to be of use. A similar result sometimes follows a fit of apoplexy. 4. Certain diseases are always attended with a diminution, and sometimes with a complete loss of sexual power; especially diabetes, diseases of the kidneys, some forms of dyspepsia, and the latter stages of most chronic organic diseases. 5. It sometimes happens that a young man, the first time he yields to carnal temptation—or that a newly-married man on the night of his nuptials, finds himself incapable of accomplishing his wishes—through awkwardness, or timidity, or over-anxiety, or, perhaps, because on nearer inspection he finds his *chère amie* less tempting than she seemed, or because the consciousness of guilt prevails over the sense of desire. He straightway fancies himself impotent. The surgeon should cheer his spirits, and should inform him that his case is by no means uncommon: he should advise him, if married, to banish his fears; if single, to wait till he can gratify his passions legitimately in marriage.

There is a very frequent and distressing class of cases, in which the patients, generally young men of good education and refined feelings, and with vigorous development of the genital organs, believe themselves

* See Walshe on Cancer; Hughes Bennett on Cancer, p. 126; Lebert sur le Cancer, p. 674; Hannover on Epithelioma, p. 141. Paget's Lectures, vol. ii.

to be impotent, or to have spermatorrhœa ;* or perhaps to be labouring under secondary syphilis—a state designated *Syphilophobia*. These cases require very skilful and kind treatment. The malady is in reality mental; caused often by the struggle between natural passion and religious sentiment, and aggravated usually by some disorder of bodily health, such as oxaluria, or other form of poisoned blood. If the surgeon foolishly makes light of the case, or if he still more foolishly tries to argue the patient out of his malady, the patient immediately flies to the advertising quacks, to the great detriment of mind, body, and estate. The proper course to pursue is, to improve the general health. The writer has cured many an inveterate case of imagined impotence or syphilis by a few grain doses of calomel, followed by combinations of quinine with Epsom salts, and afterwards steel or zinc.

Retention of the testes in the abdomen is considered by some as a cause of impotence, although in many instances, when the gland is held in the iliac fossa by extensive adhesions, atrophy follows, yet it has often been found perfectly plump and healthy. The nearer it is to the scrotum, the more likely it is to be active, especially if protected from injury by a proper apparatus (see p. 370).

Lastly, impotence may be produced by premature and excessive venery, or by the practice of self-pollution. Such cases not unfrequently come under the observation of the London practitioner. The sexual organs have been rendered so weak and irritable, that the least excitement from a lascivious idea or from the mere friction of the clothes, brings on an imperfect erection, followed immediately by the discharge of a thin fluid. The erection is so imperfect, and followed so soon by the discharge, that the patient is incompetent for sexual connexion; and the frequent and abundant losses of seminal fluid (whence the term *spermatorrhœa* is given to this malady), together with the patient's consciousness of his own imperfection, brings on a most miserable state of bodily weakness and mental despondency. General tonics, and cold-shower-bathing, will do something to relieve this state; but the most essential thing is, the observance of *perfect chastity* of idea, so that all excitement may be avoided. It may be supposed that the prostatic portion of the urethra, in these cases, is preternaturally irritable; and this condition of the parts at the orifice of the seminal ducts may tend greatly to keep up the excessive secretion, and to promote the action by which it is expelled. It is a very important indication, therefore, to lessen this sensitiveness, and so interrupt the chain of morbid phenomena.

The author has found great benefit from the use of enemata of cold water at bedtime; cold or tepid salt hip-baths; F. 179, 181, and opiate suppositories. He has seen cases in which a preternatural

* The patient should be instructed that a periodic discharge of seminal fluid, at intervals of three weeks or a month, is as natural a phenomenon as ovulation and menstruation in the female. Of course, if frequent or excessive, it is weakening; but it is readily brought within limits by treatment.

irritability of the ejaculatory apparatus, with involuntary nocturnal emissions, even of a bloody fluid, together with very great pain in the back, languor, and despondency of mind, have been caused by the presence of irritating urine, containing oxalate of lime, and cured by the means described in the section on Urinary Deposits. Lastly, there is the application of nitrate of silver to the prostatic portion of the urethra, as directed at p. 615; of which it may be said, that if sometimes useful, it is often useless, if not mischievous. Any tampering with, and every means of directing the patient's thoughts to the genital organs, should be avoided if possible.

CHAPTER XXII.

SURGICAL DISEASES OF THE FEMALE GENITALS.

I. CATARRHAL VULVITIS.—Women—even young girls—are subject to mucous or purulent discharges from the parts at the entrance of the vagina; which may also perhaps be excoriated. Purgatives, tonics, soap and water, and astringent lotions are the remedies. (See p. 201.)

II. NOMA signifies a phagedænic affection of the labia pudendi of young female children, precisely resembling the *cancrum oris*, p. 473, in its causes, and nature, and symptoms. After two or three days of low fever, the little patient is observed to suffer considerably whilst making water, and on examination, the labia present a livid erysipelatous redness and vesications, that are rapidly followed by phagedænic ulcers. The disease is very frequently fatal. The treatment is the same as directed for cancrum oris. The surgeon must be very careful not to mistake this or the preceding affection for venereal disease; an error common enough among parents. In the year 1853 there were several criminal trials at Dublin of persons falsely accused of tampering with children.*

III. VESICO-VAGINA FISTULA signifies a communication between the bladder and the vagina. It generally results from sloughing of the parts after a tedious labour.† As soon as it is discovered the patient should be made to lie on her face; the utmost cleanliness should be enforced by means of astringent injections and fomentations; by which means the cicatrization and contraction of the aperture will be pro-

* Kinder Wood on a fatal affection of the Pudenda of Female Children, Med. Chir. Trans., vol. vii. p. 84. Wilde, Med. Times, Oct. 1853.

† With the improvement of midwifery, and with less cowardice and delay in resorting to the forceps, this accident ought to disappear. Midwifery lecturers are to blame for the absurd overcaution which they inculcate with regard to the forceps. It is, by-the-by, curious to remark, that out of nineteen cases related in Remarks on the Urethro-Vaginal, and Vesico-Vaginal Fistulæ, by N. Bozeman, M.D., of Montgomery, Ala, 1857, fourteen occurred in coloured *girls*, or negresses.

moted. When the spontaneous processes of cure are carried so far as can be, art must step in.

The application of a cautery at a black heat to the edges of the fissure, at intervals of from ten to thirty days, so as to get them not to slough, but to contract, is much used, and with very excellent results, by Dr. Arthur Farre, both in the vesico- and recto-vaginal fistulæ and in lacerations of the perinæum; and the writer has seen it used with excellent effect in a case of recto-vaginal fistula by Dr. Tanner.

But in most of such cases an operation should be performed as follows:—The patient, gently chloroformed, must be comfortably supported, leaning forward on her knees, with the chest at a lower level than the

abdomen. When a woman who has borne children, with a largish belly and somewhat relaxed, is placed in this position, and when the orifice of the vagina is dilated with the fingers, or with a single-bladed speculum, resembling a spoon with the edges rounded off, the downward pressure of the abdominal viscera will expand the vagina, air will enter audibly, and a good view will be obtained of the whole

* Vesico-vaginal fistula. Sketch of a patient in the position described in the text, with a catheter in the bladder: *a*, edge of fistula.

canal, and of the cervix uteri at its extremity.* Or she may be in the lithotomy position. Then, while an assistant on either side separates the labia and keeps the rectum out of the way by finger or bent spoon-handle, the operator, by means of forceps or hook and long narrow knife, entirely and thoroughly denudes or *vivifies*, as the French say, the edges of the aperture, especially at each extremity. Too much

care cannot be taken in this respect. Then sutures are to be passed either by means of a needle with a fish-hook curve, which the writer devised for the purpose, first through the farther, then through the nearer edge; the needle being so curved that it can be introduced and withdrawn without wounding the vagina, and so that the operator's hand does not get in the way of his eyes. When a sufficient number have been passed, their ends may be passed through a bar of white metal, drilled with holes; one bar on the farther the other on the nearer side of the fissure, so as to act as quill sutures: the ends of the wires to be secured by split shot, pushed on the wires close up to the bar, then pinched by forceps to make them bite the wires. This is Dr. Marion Sims's plan.

A better needle, however, is the hollow one represented here, de-

* This fact has long been applied by the author in practice; and has been prominently stated by Dr. Marion Sims in his Clinical Remarks on Uterine Surgery, Lancet, 1861, vol. ii.

scribed by Dr. Simpson, and said to have been devised by Mr. Startin. Other modes of securing the wire sutures, are—the *metallic button* of Dr. Bozeman, a plate of lead adapted in size and curvature to fit the spot; and perforated with holes through which each pair of ligatures is drawn, and then fixed with split shot. This apparatus insures great fixity of the parts, and its use has been attended with great success. Instead of using a shot the wires may be twisted.

Dr. Simpson has devised a wire splint, to hold the margins, or rather the whole site of the wound steadily, and to hold the sutures. It is made by twisting fifteen or twenty strands of fine iron thread into a cord; the ends of which are plaited together in a circle, which may

be moulded so as to surround the wound. A sufficient number of apertures is made with a common borer, to allow the sutures to pass. The above figure shows it applied.*

The annexed engravings represent needles adapted for wire sutures in these or any other operations. Mr. Price's has two holes, about

half an inch apart, and the upper and under surfaces grooved; wire passed from hole below to that above; end of wire doubled to hold it.

Mr. Murray's has a groove and open box end.

* Copied from Dr. Simpson's Lecture in Med. Times and Gaz., Jan. 8th, 1859. Dr. Simpson prefers the common blue annealed iron wire, No. 32. The best is manufactured by Cockers, of Sheffield.

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and of the lower part of the vagina between must be freely denuded of mucous membrane. Hæmorrhage must be checked by iced water, or if necessary by ligatures; then the parts are to be brought together by the quill suture. Three good-sized ligatures should be passed quite deeply through the tissues, and be attached to a piece of bougie on either side, and the edges of the skin be brought together by two or three interrupted sutures. Then the finger being introduced into the anus, and a straight probe-pointed bistoury by its side, the sphincter should be divided. The catheter must be retained after the operation, to prevent the contact of urine with the wound, opium be freely given, and the bowels kept confined for four or five days.* It is very important in this operation (especially if it be associated, as it often is, with prolapse of the uterus) to have a broad and extensive surface of adhesion by denuding the mucous membrane sufficiently, and taking deep hold with the sutures, so as to bring together firmly the elastic fascia which supports the perinæum on each side. If this is not done, dilatation speedily takes place of the cicatrix, producing a thin stretched and feebly resisting perinæum. Generally it is advisable to employ, superficially, the common interrupted suture, in addition to the deep quilled suture.

VI. THE CATHETER may be easily introduced into the female urethra with one hand, thus:—The surgeon holding it like a pen, but with its point on the tip of the forefinger, passes the forefinger between

the labia, and feels for the meatus, placing his finger firmly upon the nodular projection behind it at the entrance to the vagina. The catheter, guided upon the finger, is then easily slipped into the orifice. Either hand may be used, according to the patient's position in bed.

VII. A VASCULAR EXCRESCENCE, varying in size from a large pin's head to that of a horse-bean, is liable to grow from the female urethra, causing great distress through its exquisite sensibility. It should be cut off, and the potassa fusa be applied to the surface to pre-

* The plan of dividing the sphincter was proposed by Horner: the necessity of opium by Davidson: all the essentials of the operation are summed up by I. B. Brown, in his work on Diseases of Women, Lond., 1854.

vent its reproduction. But, immediately after the caustic, a sponge dipped in diluted vinegar should be applied, in order to prevent injury to the surrounding sound parts; and if it is necessary to introduce the caustic within the urethra, it must be by means of a tube which has an aperture in it corresponding to the diseased surface.

VIII. IMPERFORATE HYMEN.—Sometimes this membrane completely obstructs the vagina, and causes the menstrual fluid to accumulate and distend the uterus. The impediment is easily got rid of by a crucial incision. Then all the black treacly fluid that has accumulated should be immediately syringed out with warm water, otherwise it might putrefy, and cause typhoid fever and death. The abdomen should be bandaged, and the patient be confined to her bed till the uterus has resumed its healthy size.

IX. THE LABIA may be the seat of acute inflammation, and of encysted tumours, which perhaps may be connected with the round ligament; of hernia, and of fibrous or fatty tumours. The treatment of these cases requires no distinct comments. The clitoris and nymphæ, if they grow to an inconvenient size, should be curtailed by excision.

X. VARICOCELE.—Enlargement of the veins of the labia, forming a soft tumour, which enlarges when the patient rises, and increases so as to form a most painful impediment to exercise, but disappears when she lies down. *Treatment.*—Cold bathing, and support by a fine truss, or T bandage with a pad.

XI. PROLAPSUS OF THE VAGINA is a consequence of structural debility, and is liable to follow parturition, and to accompany and aggravate congestive diseases of the womb. When the posterior wall prolapses, bringing with it the rectum, there is great distress and difficulty in getting rid of the motions; when the anterior wall with the bladder prolapses, there is a great irritability of the bladder; difficulty of emptying it; decomposition of residual urine, and other ill consequences. Cold astringent injections, tonics, baths of alum water, and firm perineal bandage (see *Bandages*), are the first set of remedies. Should these fail, it may be necessary to resort to a pessary—a thing which no one, however, should use if he can help it. Lastly, there is the ingenious operation of I. B. Brown, which consists of two parts: first, in contracting the circumference of the vagina; secondly, in uniting the posterior portions of the labia, so as to bring forward the perinæum, as it were, to act as a natural cushion and support to the prolapsed parts. The first object is accomplished by denuding a longitudinal slip each side of the vagina, bringing the cut surfaces together longitudinally, and uniting them by suture; the second, by denuding and uniting the inner surfaces of the posterior halves of the labia, as in the operation for ruptured perinæum.

XII. CANCER OF THE VULVA; fungoid bleeding projection, or scirrhous thickening, leading to deep and rapid ulceration, with adherent and hard base; must be treated as directed at p. 122.

XIII. CORRODING ULCER, EPITHÉLIOMA, ESTHIOMÈNE of Eu-

guier, ELEPHANTIASIS. The external female genitals are liable to various kinds of enlargements and of ulceration, whose nature and alliances require even yet to be further studied. 1. There is the *superficial lupus* (p. 80), affecting the young and scrofulous; puffy congestive swelling, and infiltration of the skin in soft tubercles; ulcerating in one direction, healing in another. 2. The *corroding ulcer*, or *esthiomène perforant* (p. 81), a deep glassy ulcer; base slightly infiltrated, burrowing up by side of vagina; distinguished from pure syphilitic ulcers by its rebellion to anti-syphilitic treatment, and by its not being followed by syphilitic symptoms. 3. *Elephantiasis; enlargement* of the labia and other external parts (well described by Egan); rendering them a huge, warty, fissured, and most cumbrous mass; consisting in great hypertrophy of the fibrous dermis, in infiltration of fibro-plastic matter, and, as the author believes, sometimes superadded epithelioma. 4. A combination of corroding ulceration, with hypertrophy in various forms; thickened cutis, warty excrescences, and soft tubercles. Of these various instances of disease, many owe their origin to the combined forces of filth, gonorrhœa, syphilis, and scrofula or some other kind of cachexia. The treatment must consist of, 1, cleanliness and astringents; 2, anti-scrofulous, or anti-syphilitic remedies, according to circumstances; 3, these failing, excision of the diseased parts; either at one *coup*, or at several, according to their extent; and the destruction of corroding ulcers by the actual or some other efficient cautery.*

CHAPTER XXIII.

DISEASES OF THE BREAST.

I. HYPERTROPHY of the breasts to an enormous size is very common during the earlier months of pregnancy in plethoric women. Aperients will assist time in effecting a perfect cure. In unmarried women the same thing sometimes happens; the breasts becoming so large as to be a perfect burden. If there are any remedies they are the preparations of iodine, and the various means for insuring the healthy action of the womb.

II. BOYS AND GIRLS about the age of puberty are subject to slight swelling and tenderness of the breast, which soon disappears of itself if not interfered with.

III. LACTEAL TUMOUR.—Sometimes a lacteal duct becomes obliterated, and the milk accumulates in it, forming an oblong fluctuating tumour near the nipple. If this is punctured, milk will continue to be

* See Egan on Syphilis, p. 146; Huguier sur l'Esthiomène; Mém. de l'Acad. de Med., 1849; Lebert, Hannover, Paget, op. cit. Compare Elephantiasis Scroti, p. 664.

discharged during lactation, and, after the child is weaned, it will dry up and heal. In a very few rare instances there has been formed a

IV. LACTEAL CALCULUS.—The fluid part of the milk in an obstructed lacteal duct having been absorbed, whilst its more solid and earthy ingredients remained, and concreted into a calculous mass.

V. ABSCESS IN THE LACTEAL TUBES.—An elderly woman applied to the author some time since with a painful, elongated swelling, stretching from the nipple to the circumference of the breast. It evidently consisted of a lacteal tube which had suppurated; and, after being punctured, and yielding half an ounce of pus, it soon got well.

VI. SORE NIPPLES.—Excoriations and cracks of the nipples not only cause great pain and inconvenience in suckling, but are a frequent cause

of acute inflammation of the breast. The tannin lotion, originally recommended by the author many years ago, F. 131, and a touch with lunar caustic, to a very deep irritable fissure, were the best remedies, till the discovery of collodion; which is certainly a better means of gluing up and protecting the fissure. The nipple should be defended, if need be, from the clothes and from the child's mouth, by a metallic shield. Women who are subject to this affection should frequently wash the parts with salt and water, or solution of alum, during preg-

* This cut shows a very convenient mode of bandaging the breast. The bandage consists of a piece of linen split into two tails, of which one is fastened round the waist, whilst the other supports the breast, passes over the opposite shoulder, and is fixed to the first, behind.

nancy; or should apply every night a liniment composed of equal parts of rectified spirit and olive oil.

VII. ACUTE INFLAMMATION of the breast (*Acute Mastitis*) is known by great swelling, tenderness and pain, and fever. These symptoms are generally soon succeeded by formation of matter. The abscess, if confined by the fascial envelope of the organ, is very slow to point. This affection may occur at any period during lactation. It may be caused by cold—by too stimulating a diet—by neglect in suckling—by irritation propagated from the nipples, and by a loaded state of the bowels and defective biliary and urinary secretion. The suddenness with which it may come on is sometimes surprising. A woman may get up apparently well; may be seized with shivering, pain, swelling of the breast, violent fever, and delirium; and these symptoms as suddenly subside when calomel and black draughts have cleared away some most offensive motions.

Treatment.—At first a mild purgative, and fomentations; the milk should be drawn off, if it can be done without very much pain, and Dover's powder should be given to allay restlessness. The arm should be kept quiet in a sling. Three or four leeches, if great pain and good pulse. So soon as fluctuation is well established, a puncture should be made. And then efficient support should be given by bandages, or by cross strips of adhesive plaster, so as to take off the weight of the organ, compress the distended vessels, and prevent all bagging of matter. Likewise if, after leeches and purgatives, the tenderness and pain diminish, so that there seems a chance of resolution without suppuration, similar support is most useful. The following cut shows the manner in which the breast may be supported by strips of plaster (but those represented are too short): a sufficient number should be applied to cover the entire breast, except the nipple, and they should be long enough to go over the shoulder, so as to suspend the breast, and not allow it to drop.

VIII. CHRONIC INFLAMMATION may be a sequel of the acute; or may be of a scrofulous nature. Swelling and considerable hardness of part, or of the whole of the breast, ending usually in burrowing suppuration, are the characters; tonics, pressure, and free puncture of abscesses in the most depending position at which they show a tendency to point, the remedies.

IX. NEURALGIA OF THE BREAST may exist *pur et simple;* or may (as more frequently happens) be superadded to a small glandular tumour. Extreme pain, aggravated at each monthly period, and out of proportion to all local structural disease (if any) is the characteristic. The treatment was detailed in the section on Neuralgia.

X. THE TRUE HYDATID DISEASE consists in the development of a parent cyst, containing other secondary cysts, consisting of parasitic animalcules (*echinococcus hominis*) floating in a clear limpid water. It presents a globular oval hard tumour, attended with more or less pain, but no derangement of the general health. As it increases, fluctuation becomes perceptible, and the skin becomes distended and ulcerates. The

cyst may be punctured and injected with a strong solution of the iodide or bromide of potassium (p. 173), and allowed to suppurate, or may be excised, which is preferable.

XI. PARTIAL HYPERTROPHY (*Chronic Mammary Tumour*, of Cooper; *Sero-Cystic Disease*, of Brodie; *Imperfect Hypertrophy* (*adenocele*), of Birkett; *Glandular Tumour*, of Paget).—Morbid growths of many kinds may be developed upon or near the breast, or

within it; including enchondromatous, fatty, and vascular tumours. But the morbid growth which requires to be most carefully studied, and compared with cancer, is *Partial Hypertrophy*, or *Glandular Tumour*.

In this, three things will probably be met with. 1. A development of more or less perfect *gland tissue*, the characters of which are delineated at p. 108. 2. Concurrently with this, a hypertrophy of the *fibrous tissue* (p. 103), which envelopes and intersects the gland; together with *fibro-plastic* matter, more or less developed into tissue, firm or gelatinous. 3. In the meshes of this interstitial fibrous tissue, *cysts*, or cavities filled with a serous fluid, coffee-ground matter, or other form of altered or decomposed blood or pus, are exceedingly liable to form

* Mode of supporting the breast by strapping.

(p. 109). The growth of glandular or fibro-plastic matter, projecting into the cavities of the cysts, was formerly designated by the name *sero-cystic sarcoma*. The abundant formation of epithelium has induced some persons, most improperly, to describe this disease as *epithelial cancer*.

We may add that portions are often found softened, and in a state of fatty decay. The growth is usually slow. The size attained may be enormous. Mr. Fergusson, in 1853, removed one weighing twenty-seven pounds. No *age* is exempt; yet the majority of cases occur in women under thirty-five. The tumour generally commences at the circumference of the breast, and is produced by the hypertrophy of one

lobule. It is moveable under the skin; feels granulated just as the natural organ does when its tissue is developed by lactation or during menstruation; may increase so as to cover over and hide, or cause atrophy of the remainder of the organ; yet is not attended with retraction of the nipple, or adhesions, or enlargement of the lymphatic glands. There may be *pain*, especially at the menstrual period, at which time the entire gland becomes more enlarged and tender; yet not the wearing pain of cancer. When cysts are formed, fluctuation becomes perceptible at one or more points; the disease increases slowly or quickly; at last it distends the skin, and a round aperture is formed, from which a cauliflower excrescence sprouts out; and the pain and discharge may be very ruinous to the health.

The disease may last almost any number of years, and may increase to a great size without greatly affecting the health. In some cases it disappears of itself; in others it remains stationary. The writer had

* From a preparation of the late Dr. Hooper's, now in the King's College Museum. It shows cysts in the breasts, some empty, others partially filled, others entirely filled with new growth of glandular tissue.

(at the date of the 6th edition, 1853) three ladies under his care with this tumour. In one, the mother of eleven children, it came after the health had been broken down by puerperal fever, which completely hindered suckling. This patient (1855) had got well spontaneously. In the second, a very feeble and anæmic person, it came shortly after weaning one child, and disappeared during the next pregnancy. In the third, it was first noticed at nineteen: she was married at twenty-one; at twenty-three the tumour was slowly on the increase, and was excised by Mr. Henry Lee; it furnished a capital specimen of the disease. In a year after the operation, the tumour returned; continued stationary for two years; and in the year 1859, had disappeared, concurrently with great improvement in the health.

Treatment.—In the early stages, tonics, and measures adapted to regulate the bowels and the menstrual functions—such as the iodide of potassium with bark, the iodide of iron, saline and chalybeate mineral waters, &c.—should be administered at discretion. If it should be hot, swelled, and painful, a few leeches may be of use. Lebert speaks highly of the tepid douche, and of ointment of iodide of lead in the intervals. The breast should be enveloped in cotton wool. *Severe* pain or distension may be relieved by opiate or belladonna liniment. Lastly, should the growth increase rapidly, with cyst formation or suppuration, the part of the breast containing it should be extirpated.

XII. GLAND CYSTS (p. 109), not like the last, developed between the lobules, but consisting of an expansion of obstructed gland ducts, may be situated on the surface, in the centre of, or behind the organ; and may be of various sizes, though rarely larger than a filbert. They are lined with epithelium, and enclose a yellow, reddish, or green mucous fluid, containing milky and fatty globules and epithelium, which last accumulates after a time, and renders the contents of the cyst more solid. Serous fluid sometimes exudes from the nipple.*

In a patient of the author's, aged 46, a cystic tumour, size of a walnut, has existed twenty years close to the nipple, *which it causes to retract;* is swelled and painful during the catamenia; a little bloody serum can be squeezed out, or runs out of itself. The cyst is evidently composed of a dilated duct, and has a bit of hypertrophied gland tissue close to it.

These cysts may be combined with glandular tumour: but if not, and if they increase, puncture so as to empty them, and moderate pressure may be tried, when perhaps they may shrink with or without suppuration. But if great irritation and discharge are created, a part or the whole of the organ should be removed.

XII. CANCER of the breast is, according to Lebert, of the hard or scirrhous variety, in three-fifths of the number of cases; of the soft or medullary in one-fifth; and of intermediate forms, including a few rare and exceptional cases of melanotic and colloid cancer, in the other fifth. Paget believes that of every hundred primary hard cancers, ninety-five

* See Birkett on Diseases of the Breast, Lond., 1856.

would be found in the breast; and rates the number of soft cancers in this part much lower than Lebert does.

Symptoms.—It is usually felt first as a tumour about the size of a nut; not tender nor painful; situated in, and incorporated with, some part of the breast. It gradually increases, feels excessively hard, becomes irregular or tuberculated, and not circumscribed from the surrounding parts. Its tendency is to increase in breadth, rather than in prominence, and to involve more and more of the gland. In fact, the gland may appear shrunken; especially when the disease produces adhesion of the skin and nipple and atrophy of the subcutaneous fatty tissue. From this cause the nipple and the skin often become drawn in and puckered. During this first period, the general health may be good, and the patient only be troubled with slight pains, especially about the menstrual times.

The *second stage* is one of active local progress. Stabbing or lancinating pains of great severity come on; the cancer more and more involves the skin, which reddens, then excoriates, then ulcerates away, forming a chasm with hard jagged edges, greenish ashy surface, most foully-smelling discharge, and pain like coals of fire. This ulcer may be almost stationary for years; or may increase rapidly by sloughing; or may throw up fungous granulations; or even at some part may undergo an imperfect cicatrization. But slowly or quickly, on the disease goes. Adhesion of the gland to the pectoral muscle; cancerous infiltration of the axillary glands and increasing decay of health and strength, complete the usual phenomena of this stage.

In the *third stage*, other organs become affected. Severe rheumatic pains, deposit of cancer in the bones, with perhaps fracture; cancerous deposits in the liver, with consequent sickness, and failure of appetite; or in the uterus, or the breast; infiltration of the ribs and intercostal muscles, and effusion into the pleura, with pleuritic pain and dyspnœa: these added to the constantly-increasing original disease, at last wear out the miserable remnant of the patient's life.

The average age at which this disease begins, is from thirty-five to fifty-five. Of 62 cases adduced by Lebert, 158 by Paget, 147 by Birkett, 22 only appeared before thirty. There is no evidence whatever of any essential connection of this disease with marriage, celibacy, sterility, previous disease, mental causes, or external violence. The average duration of life is less than four years; but in this matter there is great diversity. In some cases the disease begins with a furious onslaught, and kills in a few months. The younger and more robust the patient, and the more rapid the early symptoms, the worse will the prognosis be. On the contrary, cancer affecting the aged and atrophied, may linger on for many years, and kill the patient by inches.

Treatment.—The first question that will arise, is the propriety of extirpation; regarding which we must refer to p. 121. Suffice it to say, that although it were proved that the operation does not prolong life in the end; although the disease is sure to return in the cicatrix, in the other breast, *or elsewhere*; yet, that the surgeon should advise

it as a means of procuring about a twelvemonth's relief from the weariness and anxiety of disease; provided, 1, that the internal organs are sound, and the health such that the operation itself is not likely to be mortal; and 2, that the breast is yet not so adherent, nor the skin and glands not so diseased as to render it unlikely that the wound will cicatrize. Again, an exceedingly rapid progress, especially of soft cancer, in young persons, may render the operation hopeless; whilst an exceedingly slow progress in the old would render it unnecessary.

Palliatives.—But, in proportion to the hopelessness of cure, so ought our efforts to be strenuous in devising means for assuaging the bodily torments, the loathsomeness, the mental despondency, which render the sufferer insupportable to herself and to others. In addition to the directions which we have already given (p. 123), we may subjoin the following brief hints to the younger practitioner.

In the first place, study the effects of opium and other narcotics on each individual patient. Learn the form and combination which serve in smallest doses to procure sleep by night, and to allay pain by day, with least headache and loss of appetite. When the ordinary forms of opium or morphia do not agree, try the black drop; the preparations of Squire, Battley, or Jeremie; make great use of opiates locally (F. 26 to 32). Try chloroform inhalation in its mildest degree. We have observed great relief to the miserable rheumatic pains from daily administration of sulphuric or chloric æther; or of negus or good beer. Lebert speaks highly of the value of sulphate of quinine for the same purpose (F. 3). Thus death will be postponed so far as it is induced by the exhaustion of pain. In the next place, for a disorder whose starting-point is some error of nutrition, it is more than probable, that, if any remedy is to be found, it will be in some article of diet, which shall supply to the cancer matter, the complemental material required for its conversion into healthy plastic matter. Besides the articles mentioned at p. 94, turtle soup, eels, American oysters, Edinburgh ale, Tent or Constantia, oatmeal porridge, with wine or beer, may give a stimulus to nutrition. As to particular symptoms, the *œdema of the arm*, which is often such a distressing complication of the later stages of this disease, may be somewhat retarded by bandages, and by keeping the limb in an elevated posture. Blisters near the shoulder, and punctures of the skin, may be tried when it becomes excessive. Itchings may be allayed by glycerine, infusion of tobacco, tincture of aconite or of belladonna painted on the part; or by baths of bran or gelatine; or by the local application of chloroform, and especially by astringents, as the tincture of galls, or solution of tannin. It is important to save the skin from excoriation as long as possible, by tannin, black wash, bismuth, &c.

XIV. EXTIRPATION OF THE BREAST is thus performed:—The patient being narcotized and on a convenient couch, an assistant takes the arm of the affected side and holds it out, so as to put the pectoralis on the stretch. The surgeon then makes a semi-elliptical incision below the nipple along the lower border of the pectoralis major, and another on the upper and inner side of the nipple, so as to include that part

between them. He next dissects out the lower and outer part of the gland, quite down to the pectoralis (taking care not to get behind that muscle), and then, cutting from below upwards, he separates the remainder. If an adjacent gland is enlarged, the incisions should be managed so as to include it also. When the mass is removed, its surface should be wiped and examined, and the wound should also be well examined, to ascertain that no part of the gland, and that no hardened or discoloured portions of cellular tissue or of muscular fibre, are left behind. Arteries are then to be tied, and the patient to be put to bed, and when all oozing has ceased, sutures and a few strips of adhesive plaster may be applied. If desirable to effect gentle pressure on the wound, to stop oozing, a small flat sand-bag, says Mr. Birkett, may be placed upon the flaps.

XV. MEN occasionally suffer from cancer of the breast, and other morbid growths, which manifest themselves in the same manner, and require the same treatment as in the female.*

CHAPTER XXIV.

DISEASES OF THE HANDS AND FEET—CLUB-FOOT, AND OTHER DEFORMITIES OF THE LIMBS.

I. CLUB-FOOT (TALIPES) signifies a deformity of the foot, produced by rigidity and contraction of various muscles of the leg. 1. In the most simple and most common variety, *talipes equinus*, the heel merely is raised, so that the patient walks on the ball of the foot. 2. In the *talipes varus*, which is the more common *congenital* form of club-foot, the distortion is much more complex. In the first place the heel is raised; secondly, the inner edge of the foot is drawn upwards; and thirdly, the anterior two-thirds of the foot are twisted inwards; so that the patient walks on the outer edge, and in confirmed cases, on the dorsum of the foot, and outer ankle. 3. In the *talipes valgus* the outer edge of the foot is raised up, and the patient walks on the inner ankle. (See fig. 3, p. 693.) 4. In the *talipes calcaneus* the toes are raised and the heel is depressed, so that the patient walks upon it.

There are also compound varieties; as the talipes *equino-varus*, *equino-valgus*, and *calcaneo-valgus*; whose names sufficiently point out their nature.

Each of these deformities may be *congenital*, or may come on after birth, with the exception of the talipes equinus, respecting which, it is very doubtful if it is ever congenital.

Causes.—Their origin may be traced to contraction and shortening

* For all necessary information, see Mr. Birkett's Treatise on Diseases of the Breast; Lebert, op. cit.; Paget, Lectures, vol. ii.

of muscles. The *exciting causes* may be any circumstances that interfere with the supply of nervous influence, or with the proper nutrition of the muscles. Thus, to take the simplest case first, it may be caused by primary spasm affecting one or many muscles; and this again may be dependent (in non-congenital cases), 1st, on a rheumatic or sub-inflammatory state of those muscles or their nerves; 2ndly, on irritation propagated directly from the spinal cord, from actual disorder of that part; 3rdly, on irritation reflected from the spinal cord, but originating in disorder of some other organ, especially of the bowels. The cause of intra-uterine spasm is probably some shock to the nervous system of the mother.

1.*

Secondly, instead of being caused by primary spasm of any given muscles, it (in non-congenital cases) may be caused by primary paralysis of their antagonists; so that there being no proper balance of forces about the ankle joint, the foot becomes fixed in one of the above-mentioned deformed positions; probably by a process of *adapted atrophy*; which is, in plain English, a process by which a muscle shortens itself permanently, if long placed in a shortened position.

2.†

Thirdly. It may be caused as a sequel of

* Talipes equinus, from a cast in the King's College Museum.
† Talipes varus, from the King's College Museum.

bruises, injuries, or disease of joints. (See Spurious Anchylosis, p. 303.)

General Treatment.—The indications are, *first* (in non-congenital cases), to remove all causes, and to soothe spasm, and give power to palsied muscles. If any case comes under treatment, before the contracted muscles have become fixed in their rigidity, this may be done by purgatives, and other means of sweeping away excentric causes of irritation; or by fomentations and anti-rheumatic remedies, as the case may be. The writer has met, in his practice as an accoucheur, with cases of valgus in newly-born children from spasm of the peronæi and other muscles which raise the outer edge of the foot; in which castor-oil and friction, and manipulation, effected a cure; in other cases, if the spasm has seemed obstinate, he has divided whatever tendons were rigid. In one case this form of spasmodic valgus was associated with wry neck. Both did well. Tonics, especially steel, are of service with older children.

3.*

The cases in which deformity arises from paralysis are less promising. But here a distinction must be drawn between local paralysis and general. Local paralysis, such as the blighting and atrophy of an entire limb, from exposure to cold, or even from fever, or irritation of teething, is curable by friction, galvanism, and other means of keeping the muscles from lapsing into quietude and degeneration, combined with tonics and proper nourishment. But when it depends on primary disease of the nervous centres, such as a hydrocephalic attack in a strumous child, and in adult paralysis generally, it is much less so.

As to mechanical measures, in slight cases, splints of gutta percha, or of wood, with bandages, and great care, may do everything. Mr. Barwell, of Charing Cross Hospital, advocates a system of treatment by means of vulcanized india-rubber bands, acting like springs, to supplement the inefficient action of the weakened antagonistic muscles. The springs are applied over these muscles, and act in their direction; they have a thin plate of flexible metal at each end, which is attached by adhesive plaster placed round the limb to keep them in place. But in severe cases, delay is injurious; and from the healthy condition of the muscles at birth, active treatment will be more likely to be satisfactory if adopted early.

Therefore if these measures do no speedy good, it is better

* *Talipes valgus, from* Mr. W. Adams's collection.

soon to resort to Stromeyer's operation of *subcutaneous tenotomy*; our knowledge of which, and in fact of the entire pathology of these deformities, and the establishment of what is now called *orthopædic surgery*, is dated from the publication of Dr. Little's Thesis, in 1837.*

The rationale of this operation may readily be comprehended. The tendon being divided, its separated extremities heal by a new connective tissue, which renders it longer, and which, while recent, may be stretched to any desired length. Thus the mechanical shortening of the muscle is neutralized. At the same time, the antagonist muscles, which become wasted and inert, are relieved from a constant state of tension, and are enabled to resume their natural functions, so that the limb has a chance of increasing in strength and bulk. The operation is performed thus:—The tendon is put on the stretch; and a narrow sharp-pointed knife is thrust through the skin on one side of it; then its edge is turned against the tendon, and made to divide it as it is being withdrawn. The tendon to be divided is the tendo Achillis in the talipes *equinus*. The same in the *varus*, and those of the tibialis posticus, anticus, and flexor longus digitorum. In the *valgus*, the peronæi and the extensor longus digitorum: any tendons, in fact, which oppose the restoration of the foot to its proper position. It is often expedient to divide a portion of the plantar fascia, or of the muscles of the sole of the foot. Fasciæ contract under chronic rheumatism. Immediately after the operation, the foot should be put quietly up with splint and roller, with a dossil of lint and strip of plaster over the punctures, and be retained in the same position of deformity as before the operation. In the course of four or five days, apparatus must be adapted for bringing the part into proper shape.

II. TALIPES VARUS.—In the foregoing paragraphs we have described club-foot generally. Now we proceed to detail the anatomy more particularly of the talipes varus, and in so doing avail ourselves of the description, by Mr. W. Adams,† of a severe form in an adult female: since essentially similar deviations, especially in the head of the astragalus, exist in the fœtus at birth.‡

In reference to this deformity, the foot may be regarded as consisting of two portions, which move in different directions upon two distinct centres of motion. The division between these two portions corresponds to the articulation between the first and second rows of the tarsal bones, viz.:—between the astragalus and scaphoid, and the calcis and cuboid bones (indicated by the oblique dotted line in fig. 6). At this great transverse tarsal joint, a considerable amount of motion

* Symbolæ ad Talipedum Cognoscendum, Berol., 1837. See also Dr. Little's Treatise on Deformities, Lond., 1853.

† The writer has to thank Mr. Adams for the three cuts illustrative of the anatomy, which are taken from his original paper in Trans. of Pathol. Soc., vol. vi., 1855.

‡ See vol. iii. of the Trans. of the Pathol. Soc., where representations of the fœtal astragalus are given.

exists in the healthy condition of the foot; and in talipes varus the inversion of the foot takes place essentially from this centre of motion, and involves only the anterior two-thirds of the foot. The posterior third of the foot, consisting of the os calcis and astragalus, has its centre of motion in the ankle-joint, from the construction of which it can only move in the direction of flexion and extension; at least this is essentially the direction of its motion.

5.*

In a severe case as that represented, the posterior third of the foot is elevated by the action of the muscles of the calf upon the os calcis, and the astragalus is raised from its horizontal into a vertical position; its centre of motion being at the ankle-joint. The anterior two-thirds of the foot are drawn inwards and upwards, producing the inversion characteristic of varus, by contraction of the tibialis anticus and posticus, the flexor longus digitorum, and in severe cases the extensor and flexor pollicis; its centre of motion at the great tarsal joint is indicated by the dotted line in figs. 6 and 7. In this movement

6.†

* *Talipes varus*; outer side of leg.
† *Posterior aspect* of leg, and sole of foot.

the navicular bone is drawn directly under the inner malleolus (see fig. 7). These are the only movements essential to varus; but, in some cases, shortening of the foot takes place from contraction of the plantar fascia and flexor brevis—and also in severe cases, after the period of walking, more or less transverse rotation of the foot takes place from the superincumbent weight telling upon the foot in the act of progression, so as to narrow the transverse arch, and approximate the fifth to the first metatarsal bones, as seen in fig. 6.

As a result of these changes in position affecting different portions of the foot, the bones become somewhat misshapen. The head of the astragalus presents the most important deviation in form, which Mr. Adams, in opposition to Scarpa and Little, describes as existing at birth,

7.*

and regards as an adaptation of the bone in its cartilaginous condition to the altered position of the navicular bone. In a severe case, the head of the astragalus, instead of its regularly convex surface directed anteriorly, as in the healthy foot, presents two articular facets at right angles to each other, and divided by an abrupt line; one, the larger, looking directly inwards, and articulating with the displaced navicular bone; the other, looking directly forwards, is left exposed by the altered portion of the navicular bone, and covered only by the elongated portion of the ligament which in a healthy state connects these bones.

The most important alterations in the direction of the *tendons* relate to those of the anterior and posterior tibial muscles. The anterior

* Anterior aspect of leg, and dorsum of foot.

tibial tendon deviates to the inner side, and crosses the inner malleolus in a curved direction downwards and backwards in proportion to the severity of the case. The posterior tibial tendon does not pass from *behind* the inner ankle obliquely downwards and forwards, beneath and then in front of this process towards the navicular bone, as in a state of health; because the navicular bone itself is displaced inwards, backwards and upwards, by the contraction of the tibialis posticus muscle, so as to be held in contact, and articulate with the inner malleolus. The tendon, therefore, passes directly *downwards* to its insertion, or even with a slight inclination *backwards*.* In fig. 6, this tendon turns a little under the malleolus to reach the navicular.

The *ligaments* are elongated in front of the ankle-joint, and on the convexity of the foot, and shortened in the sole of the foot and behind the ankle-joint, in proportion to the severity of the case, and its duration.

Treatment.—In the cure of talipes varus, the great practical rule is to divide the treatment into two distinct stages, and to accomplish the objects of the first stage very thoroughly before commencing the second.

In the *first* stage the *inversion* of the foot is to be overcome by division of the anterior and posterior tibial tendons, and that of the flexor

†

longus digitorum; and then by bandaging the foot to a straight splint placed on the outside of the leg extending to the knee. For an infant

* As in case exhibited to the Pathological Society by Mr. H. Thompson, vol. vi., p. 257.

† The above four cuts, for which the author has to thank Mr. W. Adams, exhibit—1, talipes varus; 2, the bandage applied after division of the tibialis tendons; 3, the distortion reduced to simple equinus; 4, restoration complete.

the splint should be 1½ inch in width and made of wood, or sheet iron, softly padded. When by this means the foot is sufficiently everted so as to form a straight line with the leg, and does not exhibit any disposition to turn inwards upon the removal of the bandage; when, in fact, instead of varus, a state of extreme *equinus* has been produced,—the *second* stage may be commenced. This consists in dividing the tendo Achillis, and subsequently bringing down the heel by means of a Scarpa's shoe; or in slight infantile cases the foot may be bandaged to a bent splint applied in front of the ankle-joint. In slight cases it is by some recommended to divide all the tendons at once, but the objects are best accomplished by dividing the treatment into two stages.

In severe adult cases, and where the deformity is extreme, and accompanied with much rigidity, the same principle is to be followed, but a more complicated apparatus is desirable. That invented by Mr. Adams, and described in his lectures on "Orthopædic Surgery," appears to be well adapted for these cases.*

III.—Weak Ankles and Flat Foot.—In this affection the foot is flattened, its arch is sunk, and the astragalus forms a projection below the internal malleolus, rendering the internal border of the foot convex, instead of concave. In bad cases the inner ankle almost touches the ground, and the patient walks with great pain and lameness. This affection depends on weakness of the muscles, especially of the tibialis anticus; also on undue curvature of the tibia; it is often congenital: and affects larger numbers of the English than of the Irish.

Treatment.—The patient should wear shoes or boots with high heels, and with the inner edge of the heel much thicker than the outer. He should also be directed to turn the foot out very little, if at all. Benefit may also be derived from a well-applied bandage, such as is represented at p. 72. It should always be applied so as to be carried round the ankle from the inner side of the foot. In severe cases the patient should wear a boot with a piece of steel or whalebone fastened to the sole, and passing perpendicularly upwards to the middle of the inner side of the leg, and having an india-rubber pad to support the arch of the foot.† An india-rubber spring, as advised by Mr. Barwell, to supply the place of the tibialis anticus, deserves trial.

IV. Knock Knees are treated by Mr. Lonsdale on the same principles as the crooked rickety leg; by adapting a long well-padded splint to the outer side of each limb, fastening it below by straps and buckles at the outer ankles, and above by a broad belt, to which both splints are attached, and which is buckled round the body at the level of the hollow part of the loins. The splints should be hindered from coming too far forwards, and should bear well against the trochanter and outer ankle. Meanwhile, the knee is to be drawn into its proper place by a

* Med. Times and Gazette, 1856.

† The writer has devised a good boot for these cases, made by Currie, Opera Arcade, London, S.W.

band buckled over it, and wide enough to embrace both the head of the tibia and condyles of the femur.*

V. CONTRACTION OF THE TOES.—It often happens that one of the toes is permanently elevated, and rides over its neighbours, from the habitual use of narrow boots; and the upper surface of this toe, being peculiarly exposed to friction, is generally covered with corns so painful, that many persons have been compelled to have the part amputated. Or the toe may be bent into the position of the so-called *hammer-toe*. Division of the extensor tendon (or of the flexor, in the hammer-toe variety,) may, however, enable the toe to be brought down into its place, and prevent the necessity of amputation.

VI. BUNION—a swelling over the metatarsal joint of the great toe—is a disorder which is much more talked of than understood, but which the writer has taken pains to study the varieties of, which are these: 1. A recent bursal tumour, or ganglion; thin, easily burst under the skin by pressure, which is the proper treatment. 2. A thickened bursa in the same place, filled more or less with liquid, somewhat tender and inflamed. Rest, fomentations, and anti-arthritic purges. 3. The same bursa in an indolent state; thickened but not tender. Iodine paint, or empl. hydrarg. 4. The same in a state of suppuration. To be treated like any other abscess or fistula, according to its condition.

5. Different from all these is a distortion of the foot, in which the great toe is thrown outwards, whilst the head of the metatarsal bone projects and forms a swelling on the inner side of the foot; but the foregoing bursal swellings may be superadded. This affection depends on natural formation, and the changes induced by age and labour, and, above all, by gouty enlargement. Beyond properly-fitting boots, roomy at the toes, tightly fitting the instep, there is little to be done for this; unless any tendon which pulls the toe outwards can be divided, and the joint be restored by extension with a splint; all the preceding four varieties, however, are curable.

VII. CONTRACTION OF THE FINGERS generally depends, not on any spasm of the tendons, but, as Mr. Partridge has shown the writer, on shortening and rigidity of the palmar aponeurosis and tendinous sheaths; or on a ligamentous degeneration of the areolar tissue on the palmar aspect of the fingers. This is a part of the morbid changes accompanying *chronic rheumatic arthritis*.

Treatment.—Friction and extension are of no use. But the contracted tissues may be divided by subcutaneous section. If any of the muscles of the fore-arm be rigid, its tendon may be divided.

VIII. CONGENITAL CONTRACTION OF FINGERS is generally seen in the little finger, and is not very uncommon. The finger can be straightened, but the skin is then seen to be very tightly stretched in a line at the junction of its radial with its palmar surfaces, and, as it were, continuous with the cutaneous web between the fingers. The last phalanx of the finger is always drawn inwards, as well as bent; and

* Lonsdale, Med. Gaz., June, 1849.

the contraction depends upon a congenital deficiency of the skin in the direction of the length of the finger. Thus a longitudinal web is produced by extension. The most diagnostic sign is the absence of the deep transverse folds in the skin corresponding to the bend of the joints. In contractions produced by muscular action these transverse cutaneous folds are deepened instead of being obliterated.

Treatment. — This form of contraction does not require any division of tendons, but yields to long-continued mechanical extension, constantly applied for several months, or perhaps a year. A steel plate may be adapted to the palmar and dorsal aspects of the outer third of the hand, and held in position by elastic bands, so as to afford a fixed point, and from this plate a straight and narrow bar of steel may be carried along the upper and outer margin of the finger; a little ingenuity in padding and bandaging will then bring the finger into a straight position.†

IX. WEBBED FINGERS.—This is a deformity consisting of an union of the fingers to each other. It may be congenital, or may be caused by burns. It is a most intractable affection. Mere division of the connecting skin is often of no avail, for the fingers very often grow together again when the wound heals. In order to counteract their union, a flap of skin may either be brought from the dorsum of the hand and be engrafted between the fingers, or, as Mr. Liston proposed, a perforation may first of all be made in the connecting skin near the roots of the fingers, and be prevented from closing by keeping a piece of cord in it till the edges have healed, and then the remainder of the connexion may be divided.

X. ULCERS ABOUT THE NAILS.—1. A very common and troublesome affection is that which is popularly termed "*the growth of the nails into the flesh*," and which most usually occurs by the side of the great toe. It does not, however, arise from any alteration in the nail, as its name would imply, but the contiguous soft parts are first swelled and inflamed by constant pressure against the edge from the use of

* Contraction of the palmar aponeurosis. From a dissection by Mr. Partridge.

† This instrument is constructed under Mr. W. Adams's direction by Bigg, of Leicester Square. Mr. Gumpel, of Leicester Square, is also to be recommended as a maker of light and ingenious apparatus.

tight shoes. If this state be permitted to increase, suppuration occurs, and an ulcer is formed with fungous and exquisitely sensitive granulations, in which the edge of the nail is embedded, and which often produces so much pain as totally to prevent walking.

Treatment.—The objects are to remove the irritation caused by the nail, and reduce the swelling of the soft parts. In most cases, if the nail, having been well softened by soaking in warm water, is shaved as thin as possible with a bit of glass, the pain and irritation may easily be allayed by rest for a day or two, with fomentations and poultices; and then any ulcer that has formed will soon heal, with the aid of black wash on lint, or a touch of lunar caustic. But if the case is more obstinate, the edge of the nail may be removed, by passing the sharp blade of a pair of scissors resolutely under the nail, cutting it through, and then quickly tearing away the offending portion with forceps. The pain attending this operation renders chloroform expedient.

XI. ONYCHIA MALIGNA is a peculiarly unhealthy ulcer occurring at the root of the nail, either of the fingers or toes, but more frequently of the latter. It commences with a deep-red swelling, and an oozing of a thin ichor from under the fold of skin at the root of the nail; and, lastly, an ulcer is formed, with a smooth tawny or brown surface, a very fetid sanious discharge, and swelled jagged edges of a peculiar livid dusky hue. It is in general extremely painful, especially at night. This affection often springs from acquired or inherited syphilis.

Treatment.—Mr. Wardrop recommended a course of mercury, as for tertiary syphilis. As a local application, a solution of arsenic (liq. arsen. ʒij. ad aq. ʒij.) was recommended by Mr. Abernethy; or solution of nitrate of silver, or black or yellow wash.†

XII. WHITLOW, or PARONYCHIA, signifies an abscess of the fingers. There are four kinds: the *cutaneous*, *subcutaneous*, *tendinous*, and *carbuncular*. The cutaneous whitlow consists of inflammation of the surface of the skin of the last phalanx, with burning pain, and effusion of a serous or bloody fluid which elevates the cuticle into a bladder. This is often eczematous in its character and origin. The subcutaneous is attended with greater pain and throbbing, and suppuration *under* the skin at the root of the nail, which may come off.

Treatment.—In the first two forms purgatives, followed by tonics; fomentations and poultices are the remedies. It is but seldom that incisions are demanded further than to let out the fluid from beneath the raised cuticle or skin. The dead skin or cuticle should be carefully

* From a cast in the King's College Museum.

† Vide Lawrence, Lectures, in Med. Gaz.; James Wardrop, F.R.S.E., on Diseases of the Toes and Fingers, Med. Chir. Trans., vol. v.

snipped off close all round with a small pair of scissors, and the poultice, if inflamed, applied, or lead lotion. If not inflamed, the zinc ointment is the best remedy. If the tip of the finger is long painful and tender without suppurating, it should be well pencilled with lunar caustic. The resin ointment is recommended by Mr. Vincent as an application, after the part has been opened.

The *tendinous whitlow*, or *thecal abscess*, affects the tendinous sheath or periosteum, and was described at p. 232. We may observe here, however, that if purgatives and fomentations do not speedily relieve, the finger should be freely laid open with a scalpel. The knife should be carried deep enough to feel the resistance of the bone or tendon, so as fairly to open the sheath of the latter. If matter have extended into the palm, the incision should be continued along the metacarpal bone till it freely gushes out. It is better not to cut into the spaces *between* the metacarpal bones (unless matter points there very decidedly indeed), for fear of wounding the digital artery. If it be necessary to slit up the palmar fascia, a cut should be made over the head of a metacarpal bone, in order that a director may be passed under it.

The *carbuncular whitlow* is an unhealthy infiltration of the subcutaneous tissue of the finger, brawny, slow to suppurate, and altogether resembling, and requiring the treatment of, carbuncle, p. 228.

XIII. EXOSTOSIS.—A fibrous tumour, which subsequently ossifies,

is not uncommon on the dorsal surface of the last phalanx of the great toe. To cut away the anterior half of the nail, and dissect it out, is the only useful treatment.*

* See Barwell on the Cure of Club-foot without cutting Tendons. Lond. 1863.: E. J. Chance on Bodily Deformities. Lond., 1862.

PART V.

OF THE OPERATIONS OF SURGERY.

CHAPTER I.

OF OPERATIONS IN GENERAL.

I. THE APPARATUS necessary for operations in general comprises bistouries, scalpels, saws, bone forceps, scissors, or other cutting instruments adapted for specific purposes, dissecting forceps, tenaculum, and Assalini's forceps to take up arteries; one or two tourniquets to place round the main arteries when considered advisable; plenty of hempen ligatures, iron and silver wire, hare-lip pins, needles threaded or *wired*, lint, adhesive plaster, and bandages, fine sponge, water both warm and cold, and brandy and hartshorn in case of faintness. There should also be a sufficient number of assistants—there should be one whose sole business it should be to administer the chloroform, and to watch its effects; others to keep the patient in a proper position, to hand the different instruments to the surgeon, or to assist him in other respects; besides a good light, and a bed or table, with pillows or cushions to make the patient's position as convenient as possible. Mr. Fergusson gives the useful hint that it is desirable to have delicate instruments made to shut in a handle like a pocket clasp-knife, so that they may be kept in the surgeon's waistcoat pocket till they are wanted, and that their edge or point may not be injured through the carelessness of the assistants.

Moreover, the operator should *himself see* that everything is at hand that may be wanted. It would be awkward in the middle of an amputation to send out for a saw.

II. INCISIONS.—In making incisions there are several points that demand attention. First of all, the manner of handling the knife, which, as systematic writers say, may be held either like a common dinner knife, or like a pen, or like a fiddlestick. In holding the knife in the first way, which gives the greatest power to the operator, the thumb and middle finger should be placed opposite to each other near the junction of the blade with the shaft; the first finger should be laid on the back of the blade, and the little finger used to elevate or depress the extremity of the handle. The first two positions are those which are employed commonly; the third is resorted to in cutting into the dif-

ferent layers over a hernial sac, and in sundry other delicate operations. Secondly, before commencing an incision, the skin must be gently stretched and steadied with the points of the fingers, otherwise it will be dragged along by the knife, and the incision will be ragged, and shorter than was intended. Thirdly, in cutting through the skin, the knife should be passed in at right angles to the surface, and should be at once carried down to the subcutaneous tissue; then the blade should be inclined downwards, and be made to cut through the skin to the requisite extent; and, lastly, as the incision is finished, the instrument must be again brought to a right angle with the surface. By these means the whole thickness of the skin will be cleanly divided, both at the beginning and end of the incision, without any "*tailing of the incision.*" Timid operators are apt to make the incision through the skin too limited, which embarrasses their subsequent proceedings; besides that cutting more of the skin subsequently (unless the patient is under the influence of chloroform) is very painful. In making incisions over a hernial sac, or in any place where the skin is loose, it saves time and pain to the patient to pinch up a fold of skin of a size proportionate to the length of the intended incision, to transfix it with the scalpel or bistoury, with its edge directed upwards, *i.e.*, from the patient, and to cut straight to the surface. By this means a straighter and more even incision is made down to the fascia, with great ease and expedition.

When two incisions are to be made to meet near their extremities (as, for example, the two semi-elliptical incisions in amputation of the breast), the second should fall into the first *nearly*, but *not quite at its extremity*, so that there may be no little isthmus of skin left undivided between them; again, in making a V incision, the second cut should not be begun where the first terminated, but at its other end; that is to say, it should be made *towards* the first, and not *from* it. In making a T incision likewise, the transverse cut should be made first, and the other be directed towards it. Lastly, the angle of a V incision should, if possible, be always dependent.

III. PREPARATION.—The object is to get every organ and function in as healthy and tranquil a state as possible, by regular diet and aperients, with or without tonics or sedatives, till the pulse has become quiet, the tongue clean, and the bowels regular, the liver, kidneys, and skin in good order, and the mind cheerful.

IV. THE AFTER-TREATMENT should be conducted so as to ward off the most probable sources of danger—whether sinking from shock, or from loss of blood, or the occurrence of unhealthy changes in the surface of the wound and in the fluids exuded thereby, such as give rise to the various kinds of inflammation, phlebitis, erysipelas, diffused inflammations, and pyæmia. In the observations we have made on incised wounds, we have shown how important it is that the patient should be supplied with beef-tea, and solid nourishment, and with wine in sufficient quantity to maintain a healthy state of blood; and that he should be kept quiet. The late Mr. Copeland is said always to have given his patients half a grain of opium every five or six hours

for the first two or three days after an operation, for the purpose of tranquillizing the nervous system, and his success proved the benefit of the plan.

V. AIR IN VEINS.—The entrance of large quantities of air into a vein is a most dangerous accident, that has sometimes occurred during the extirpation of tumours from the neck or axilla. A large vein being cut across, whose coats adhere to some firm textures around, so that they cannot collapse, a sort of bubbling sucking noise is suddenly heard, the patient instantly faints, and generally dies soon afterwards. On examination the right auricle is found distended with frothy blood. If any such sound should be perceived during an operation, the surgeon should instantly put his fingers on the spot that it proceeds from, and the patient, if faint, should be kept in the recumbent position with the head low, and should be well plied with brandy. The air has no noxious properties in itself, and if introduced slowly, in small quantity, does no harm; large quantities prove fatal by interfering mechanically with the action of the heart.*

CHAPTER II.

MEANS OF PRODUCING INSENSIBILITY TO PAIN.

HISTORY.—So terrible is the idea of the surgeon's knife, that it cannot be wondered at that many attempts have been made, at various times since surgery was first cultivated, to diminish the tortures which it inflicts, both in apprehension and in reality. Dr. Simpson† brings forward quotations from Dioscorides, Pliny, and Apuleius, authors of the time of the Roman empire, showing that in that age the root of the mandragore or mandrake (*atropa mandragora*), steeped in wine, was given to cause insensibility (*ποιεῖν ἀναισθησίαν*) in persons who were to be cut or cauterized; and that whilst the influence of this remedy lasted, a limb might be cut off without any pain or sensation. The seeds of the rocket (*eruca*) infused in wine were taken, according to Pliny, by criminals about to undergo the lash, in order to induce a certain recklessness or hardihood of feeling. The wine mingled with myrrh, which was offered to our Saviour before his Passion, furnishes an instance familiar to every one. The *bang*, or extract of Indian hemp, is used in India for the same purpose at the present day. Dr. Simpson has shown further that the inhalation of narcotic vapours was used as a preparatory to surgical operations in the thirteenth century.

So far concerning the ancients. The modern history of anæsthetics may be said to begin at the end of the eighteenth century, when Mr.

* For the best account of these curious cases, refer to Sir C. Bell's Practical Essays, Lond., 1841.

† Edinburgh Monthly Journal of Medical Science, December, 1847; Simpson's Obstetric Works, 1856, vol. ii.

James Moore, son of Dr. Moore of Clifford Street, and house-surgeon to St. George's Hospital, introduced a plan for diminishing the sensibility of limbs before amputation, by compressing the principal nerves. This he effected by means of an instrument resembling Signoroni's torniquet, depicted in the chapter on Aneurysm, except that his instrument consisted of a horseshoe-shaped arch of steel, with a pad at each extremity, and a screw to act upon one of the pads. Moore was permitted by John Hunter, in 1784, to try his plan upon a patient in St. George's Hospital, who had lost all his toes, and had a large irritable ulcer on his foot, and whose leg, after having been submitted to the process, was cut off below the knee by Mr. Hunter, with an extremely small amount of pain.* This plan, however, was soon given up; it is not certain, and is not without some disadvantages; for Malgaigne,† who attempted by this means to benumb a patient's leg, before an operation, found that although some amount of insensibility was produced, yet that considerable pain was caused by the instruments used for compression.

At the end of the last century the brilliant discoveries of oxygen and other gases by Priestley, Black, and Cavendish, and the fervent study of *pneumatic chemistry*, created a new, though very short-lived branch of therapeutics. The attention of the profession was hopefully directed to *pneumatic medicine*, as it was called; that is, to the possibility of curing diseases, and especially consumption, by the inhalation of various kinds of gases. A Medical Pneumatic Institution was set up at Clifton by Dr. Beddoes,‡ with huge reservoirs of gases for the use of patients. Humphry Davy, just out of his apprenticeship, was appointed superintendent in 1799;—his experiments on the inhalation of nitrous oxide, created great excitement;—S. T. Coleridge, Robert Southey, John Rickman, P. Roget, Boulton, Watt, Wedgwood, and others, since distinguished as poets and philosophers, eagerly made proof of the effects of the intoxicating gas;—the *gaz oxygenium* and *gaz acidum carbonicum*, and other gases, were introduced into the catalogues of medicinal drugs; it was now fondly hoped that we were in possession of remedies simple, and certain, for almost all maladies; and even Davy, though far from participating in the sanguine dreams of Beddoes, believed it possible that by various combinations of carburetted hydrogen and nitrous oxide, "we should be in possession of a regular series of exciting and depressing powers, applicable to every deviation of the constitution from health." But experience ruthlessly proved the fallacy of these, as of many other ingenious and plausible speculations. In the course of his experiments, however, Davy found that the nitrous oxide relieved him from headache after a profound fit of intoxication which he had brought on by drinking a bottle of wine

* A Method of Preventing or Diminishing Pain in several Operations of Surgery, by James Moore, Member of the Surgeons' Company of London. 1784.

† Malgaigne's Operative Surgery, by Brittan, p. 42.

‡ A Letter to Erasmus Darwin, M.D., on a New Method of Treating Pulmonary Consumption. By Thomas Beddoes, M.D. Bristol, 1793.

in eight minutes, with the purpose of comparing the effects of wine with those of the intoxicating gas; he also found that it mitigated the pain of cutting a wisdom tooth; and he threw out the hint that as it appeared "capable of destroying physical pain, so it might probably be used with advantage during surgical operations."*

Nothing in good earnest, however, was done: there was no established or systematic use of anæsthetic means until the year 1844, when Horace Wells, a dentist of Hartford, Conn., U.S., acting upon Davy's suggestion, both inhaled the nitrous oxide gas himself before one of his teeth was extracted, with the effect of producing a complete unconsciousness of pain, and administered it to several patients who underwent the same operation, with the same beneficial results. In the December of that year he visited Boston, and made public trial of the administration of the gas, before the Medical College of that city. But this experiment failed from want of proper management; and the failure subjected Wells to so great an amount of ridicule, that he fell sick through vexation, retired from practice as a dentist, engaged himself in stuffing and exhibiting birds and in the sale of shower-baths; afterwards came to Europe as a picture-dealer, then returned to America, became more and more unsettled in his mind, and died by his own hand in January 1848.

But the experiment of Wells, at Boston, fatal as its results were to himself, was not altogether devoid of fruit. W. G. T. Morton had been a pupil and partner of Wells, and afterwards settled in Boston, where he studied medicine and chemistry for a short time under Dr. Charles T. Jackson, and then practised as a dentist. He was the person who introduced Wells to the Medical Society of Boston, and a share of the ridicule attached to the unsuccessful experiment fell upon his shoulders. It appears that the idea of finding some means of extracting teeth without pain occupied the attention of both Morton and Jackson, and was the subject of conversation between them. Morton learned from Jackson the use of chloric ether as a local application to aching teeth. Both had read in Pereira's work on Materia Medica, that the vapour of sulphuric æther was inhaled in spasmodic asthma, chronic catarrh, and whooping-cough, and to relieve the effects caused by the inhalation of chlorine gas. In fact, for these purposes, the inhalation of ether, pure, or medicated with conium or other substances, was a well-known and not uncommon remedy, and had been spoken of by various authors from the time of Beddoes and Richard Pearson† in the latter end of the eighteenth century. Jackson himself had inhaled ether to relieve the irritation caused by accidentally breathing chlorine gas.

Morton's Discovery.—But the merit of first employing the inha-

* See Memoir of Sir H. Davy, by his Brother, John Davy, M.D., Lond., 1839; and Researches, Chemical and Philosophical, by Humphry Davy, Superintendent of the Medical Pneumatic Institution, Lond., 1800, p. 465, *et seq.*

† Short Account of Different Kinds of Airs, so far as relates to their Medicinal Use, by Richard Pearson, M.D. Birmingham, 1795.

lation of ether in such a way as to produce a decided and controllable state of insensibility to the pain of surgical operations, is undoubtedly due to Morton. He first made several experiments on himself, with imperfect success, arising from the great difficulty of procuring ether sufficiently pure; but having at last, on the 30th of December, 1846, by inhaling it from a flask through a glass tube, succeeded in making himself unconscious, he determined to try the experiment on the first fit subject that presented himself. So eager was he, that he sent out agents that afternoon to try and tempt some Yankee, with the offer of five dollars, to come and inhale the ether, and loose a tooth. No one, however, would be so tempted; but that same evening the very person wanted came of his own accord. A man, Eben H. Frost by name, applied to have a tooth extracted, and being wonderfully timid, and wishing to be mesmerised in order that he might feel no pain, he was easily persuaded to inhale some ether from a handkerchief. He soon became unconscious, and Morton extracted a bicuspid tooth, the patient knowing nothing of the operation till he recovered his senses, and saw the tooth lying on the floor. A Dr. Hayden, who held the lamp for the operator, and one Tenny, a journalist, were witnesses of the fact, and, together with the patient, immediately drew up and signed a document attesting it. And so, a new era in surgery began with the painless extraction of Frost's tooth by Morton, at 19, Tremont's Row, Boston, at nine in the evening of the 30th of September, 1846.*

Morton lost no time in prosecuting the discovery he had made, although he did not at first disclose the nature of the agent employed. He continued to make experiments at his own house; and having made the subject known to Dr. Warren, was permitted to introduce his anæsthetic agent into the practice of genuine surgery, and on the 16th of October administered the ether in the Massachusetts General Hospital, at Boston, to a patient from whom Dr. J. C. Warren removed a tumour in the neck; and on the day following to a patient from whose arm a tumour was extirpated by Dr. G. Hayward. From that time the use of the novel remedy spread rapidly in all directions; but before pursuing its history we must drop a passing word of regret at its disastrous effects on the fortunes of its discoverer. Morton endeavoured to make a mystery of the means he employed, and to secure to himself, by patent, the exclusive right of administering it. But Jackson, seeing that the thing promised to be both famous and lucrative, now laid claim to the discovery as his own, on the plea that certain information which he had given Morton, respecting the properties of ether, had directly led Morton to the use of it. To pacify Jackson, and bar any claims he might hereafter set up, he was allowed a share in the patent which was taken out. Nevertheless he sent a communication to the French Academy, in which he suppressed Morton's name, and claimed the whole discovery as his own. Meanwhile the patent turned out to be good for nothing, and Morton, who

* Ether and Chloroform, by Henry J. Bigelow, M.D. Boston, 1848.

had neglected his business, and injured his health by the excitement of his discovery, was left with his pockets empty, and even the bare honour of the invention almost wrested from him.*

From America the news of the discovery was conveyed to England in a communication from Dr. Bigelow, of Boston, to Dr. Francis Boott, and it was received most cordially.† On the 21st of December, 1846, Mr. Liston tried the ether with the best possible results in a case of amputation of the thigh, and in one of evulsion of the toe-nail. On the 31st, the writer was present when Mr. Fergusson used it in the King's College Hospital, and in less than a fortnight it was tried by almost every surgeon in the kingdom; whilst the medical periodicals for a long time were crowded with fresh instances of its powers in alleviating suffering, and with descriptions of various apparatus for administering the vapour. It was employed in every variety of surgical operation, from the Cæsarian section, in which it was used by Mr. Skey, at St. Bartholomew's Hospital, on the 25th of January, 1847, down to tooth-drawing; and in all kinds of painful examination or manipulation: it was used in cases of strangulated hernia and of dislocation, and in the obstetric operation of turning, in order to diminish the resistance of the muscles; in various cases of painful and spasmodic affections, such as tetanus, neuralgia, and spasmodic asthma; it was employed to tranquillize the insane, to detect feigned disease, and to diminish the sufferings incidental to parturition. It was used too on infants, on the aged, and on animals. Its *modus operandi* closely resembles that of chloroform; what differences exist, shall be described further on.

CHLOROFORM.—Brilliant as was the career of the ether discovery, it was destined soon to be eclipsed. Ether, whose chemical symbol is C_4H_5O, is one of a numerous class of bodies, all composed of hydrogen and carbon, with variable proportions of oxygen or some other electro-negative. Dr. J. Y. Simpson, of Edinburgh, believing that amongst these bodies some might be found equal or superior to ether, made many experiments on himself and friends with chloride of hydrocarbon, acetone, nitrous ether, and other analogous substances, and at last, on the 4th of November, 1847, in company with Dr. Keith and Dr. Matthews Duncan, found in a heavyish liquid that had been put by and almost forgotten, an agent which was manifestly superior to ether in its narcotizing virtues, and immeasurably more pleasant. This was *chloroform*. It had been investigated some time before by Dr. Glover, and it was recommended to Dr. Simpson by Mr. Waldie of Liverpool; moreover, inhalation of the fumes of that solution of it in alcohol which is known by the name of *chloric ether* had been tried some time before by Mr. Jacob Bell; but undoubtedly the merit of establishing the anæsthetic power of chloroform, as a matter-of-fact, belongs to Dr. Simp-

* See a Report of the Trustees of the Massachusetts General Hospital, with a History of the Ether Discovery, in Littell's Living Age, Boston, 18th March, 1848.

† Vide Lancet, January 2, 1847, and all the medical periodicals of that year, passim.

son. The surgeons who first performed operations with the aid of it, were Dr. Miller and Dr. Duncan, at the Royal Infirmary of Edinburgh, early in November 1847.*

Chemical History.—Chloroform is a terchloride of a hypothetical base, termed Formyle, which consists of two atoms of carbon and one of hydrogen. Hence the symbolic designation of chloroform is C_2H,Cl_3. It was discovered by Soubeiran in 1831, by Liebig in 1832, and by Mr. Samuel Guthrie, of Sacket's Harbour, New York, in the same year;† its real nature was ascertained by Dumas and Peligot in 1835. It is obtained by distilling rectified spirit with water and chloride of lime, in the proportions of four pounds of powdered chloride of lime, twelve pounds of water, and twelve fluid ounces of rectified spirit. These are mixed and distilled, so long as a dense liquid, which sinks in the water with which it comes over, is produced. It is rectified by agitating it with the strongest colourless sulphuric acid, which if it contain any impurities, such as the empyreumatic oils with which it is liable to be contaminated, at once destroys them by charring, and renders them manifest by the dark colour of the line where the chloroform and acid come into contact. It is poured off and agitated with fresh acid, if necessary, then poured carefully off into a dry stoppered bottle, and shaken with some peroxide of manganese, from which it may be decanted, fit for use.‡

Pure chloroform is a dense colourless liquid, having the specific gravity, when quite pure, of from 1·480 to 1·5. It is exceedingly volatile, and boils at about 140°. It has an agreeable sweet fruity smell and taste, and if poured on a piece of blotting-paper and evaporated, ought to leave no oily empyreumatic smell behind. By passing its vapour through a red-hot tube, it is decomposed, and hydrochloric acid is given off, which may be detected by means of paper moistened with solution of nitrate of silver. By such a process, Dr. Snow detected it in the bodies of kittens poisoned by a very minute quantity of it, and in the muscles of a child's leg which had been amputated at St. George's Hospital after inhalation of the vapour.

Chloroform is almost incombustible, thus offering an advantageous contrast to ether, from the explosion of which at least one serious accident happened during its administration.§

Effects on the Animal Economy.—When the vapour of chloroform is received into the lungs, it is absorbed into the blood, and conveyed to the nervous centres and rest of the body, upon which it soon produces very marked effects. These it is convenient to divide into *degrees*, and the division which the writer proposes as the most practically useful, is the following:—The *first*, or slightest degree, corresponds with what may be called exhilaration or slight intoxication. The pulse is quick-

* Miller's Principles of Surgery, vol. ii., p. 756.
† Cogswell, Lancet, 1847, vol. ii., p. 631; Waldie, *ib.*, p. 687.
‡ Gregory, quoted in Ranking's Abstract, vol. xi., p. 231.
§ Med. Gaz., 20th Sept. 1850.

ened, and the whole surface, especially the face and eyes, becomes suffused with red. The current of ideas is vivid and not quite under control; fear is banished; but there is perfect consciousness of all that is going on, and the severe pain of operations is still felt intensely; although the pain of disease as well as that part of suffering which depends on mental apprehension is relieved.

In the *second* degree there is no longer perfect consciousness. The patient generally neither speaks nor moves, though it is still possible for him to do both if spoken to or roused, and he is in a condition of deep drowsiness; it may sometimes be called drunken-drowsiness. All the varieties, too, of intoxication may be displayed, according to the mental peculiarity of the patient. One man is noisy, and inclined to fight; another laughs at jokes of his own making; a woman may weep or talk of her husband or children. But these phenomena are not universal, and are of very short duration; for this degree soon passes into the next, if the inhalation be prolonged, or into the first, if it be discontinued.

In the *third* degree, there is *profound sleep;* all voluntary motion and sensation are at a standstill; the eye is suffused and turned upwards, the *pupil contracted*, and the breathing slow, as in natural sleep. But yet in this degree, the eyelids wink if touched; sneezing is excited by tickling the nostrils; in fact, reflex movements are vividly performed, as they are in sleep; and though the patient lie unconscious, he is not yet sufficiently motionless for severe or prolonged surgical operations.

The *fourth* degree, which may be termed *perfect insensibility* (or *anæsthesia*, if a Greek term is better), is distinguished by the circumstance, that in addition to the profound sleep of the third degree, reflex actions are no longer excited by the nerves of common sensation. The eyeball may be touched freely without winking; the muscles are perfectly relaxed; and it is the *very beginning of this degree*, which it is desirable to produce, for the *commencement* of surgical operations.

The *fifth* degree approaches the condition known as *coma;* it is marked by tendency of the *pupil to dilate;* and slower breathing: if the quantity of vapour be increased, death may occur from coma.

If this account of the increasing effects of chloroform be carefully perused, it will be seen that it belongs to the class of substances of which opium and the various preparations of alcohol are examples. It begins by affecting the mind and consciousness. In its smallest dose it stimulates, then disturbs, then suspends the mental operations. It next diminishes the power of the nerves in receiving and communicating, and of the brain in perceiving sensations, whether arising from causes within the body, or without; hence it diminishes or abolishes the perception, and the existence of pain. It further benumbs that power called the *reflex function* of the spinal cord; the power by which the spinal cord, upon the production of any change in the nerves of sensation, puts into play the corresponding nerves of motion, and this quite automatically and independently of the will or consciousness.

This is the power by which irritation of any part causes its muscles to contract. Hence, the torpefaction of this power insures the absence of involuntary movement, and the complete relaxation of the voluntary muscles. But if carried a little too far, it abolishes breathing too, and death ensues from *apnœa*. It will be more convenient to treat of death from chloroform a little further on.

There are one or two minuter facts, which are well worth knowing. All parts of the body do not become insensible in equal times. For instance, in experiments on rats and mice with ether, Dr. Anstie found that the hind quarters remained powerless, and the muzzle insensible, after the conjunctiva, skin of the chest, and forelimbs had recovered their sensibility and mobility respectively.* "Certain portions of the skin and subcutaneous tissue," says Dr. Anstie, "retain their sensibility with extraordinary tenacity; these are the matrix of the great toe nail, the margin of the anus, and the whole of the skin of the organs of generation. It is impossible to obliterate their sensibility without pushing chloroformization to a degree which greatly surpasses that required for ordinary purposes. This explains the frequency with which death has happened in the course of anæsthesia induced from the performance of operations for phymosis, evulsion of the toe nail, hæmorrhoids, &c." Involuntary passage of urine or fæces during prolonged anæsthesia is a symptom of paralysis of the sympathetic and betokens danger.

Dose.—In speaking of the *dose* of chloroform, it must be remembered that it is not the mere quantity inhaled, without reference to time, but the quantity present in the blood in a given time, which is to be regarded. Patients may be kept under its influence a long time, and thus may inhale a large quantity with safety; but even a small quantity too rapidly inhaled, and insufficiently diluted with air, may be dangerous. Dr. Snow calculated that about twelve minims of chloroform circulating in the blood of an adult produce the second degree of narcotism, eighteen minims the degree in which operations are performed; a little more than thirty suffice to arrest respiration, and thirty-six or thirty-seven to stop the action of the heart. These numbers refer to the quantity actually circulating in the blood at a given time. It is necessary also to bear in mind, that when a patient is inhaling air highly charged with chloroform, the narcotic effects continue to increase, as Dr. Snow pointed out, for twenty seconds, after the inhalation is discontinued, owing to the absorption of the vapour remaining in the lungs. But it seems very certain, that much less is requisite for producing full insensibility in some persons than in others.†

* Stimulants and Narcotics, their Mutual Relations, with Special Researches on the Action of Alcohol, Ether, and Chloroform on the Vital Organism. By Francis E. Anstie, M.D., &c. Lond., Macmillan, 1864, pp. 302—353, &c.

† Sibson, Med. Gaz., vol. vi., p. 276; T. Wakley, Lancet, 1848, vol. i., p. 191; Dr. Snow, Med. Times, 31st August, 1850; on Death from Chloroform, London Journal of Medicine, April, 1852; case of Death, Med. Times, Oct. 19, 1853; see also Lancet, Oct. 29, 1853.—Dr. Crisp, Lancet, 1853, vol. i. How shall we

Mode of administration.—Dr. Simpson, the father of chloroformization, uses no apparatus whatever, but a simple handkerchief; and the writer, from his own experience, thinks that this unpretending way is the best in all cases in which the slighter degrees only are required; as, for instance, in common midwifery cases, and in cases in which pain has to be allayed without deep or protracted narcotism. It is equally safe, too, for the profounder degrees of insensibility required for severe operations, provided the administrant uses that degree of care without which no sane person would touch this remedy; but it is rather more wasteful of the vapour.

The patient should lie down. But if sitting, the attitude should be such as to allow of the completest repose; it, however, is much more difficult to narcotize a person sitting. He should be encouraged to be as tranquil as possible, and compose himself to sleep. A napkin should be folded into a hollow cone, and twenty minims of chloroform, by measure, be poured into its apex; then it should be held about two inches from the face of the patient, who should be instructed to begin to breathe through open mouth, slowly and deeply, so as to inhale as much of the vapour as he can. If there is any choking, the napkin should be removed a little further. The narcotism should be insinuatingly begun; so as to avoid any distressing gulping, or choking, or struggling, especially in the case of children. When the first twenty minims are exhausted, the same quantity should be repeated; and this should be done again and again at intervals, till the requisite degree of narcotism is produced. So soon as the eye, when opened, looks suffused and heavy and turned up, and the patient scarcely speaks if spoken to, then the second degree is at its acme, and the third beginning.

If the inhalation be continued, the degree of profound sleep, and next that of complete insensibility, will be established, and then, so soon, as Dr. Snow observes, as the eyelid can be raised, and the conjunctiva touched without winking, the surgeon may begin. When the operation is fairly commenced, it is not necessary to keep up so great a degree of narcotism. The patient having been secured against the first plunge of the knife, may be kept in a sufficient state of unconsciousness by an occasional whiff of the vapour, whenever his countenance exhibits any signs of feeling. In fact, during a protracted administration, when the patient is thoroughly narcotized, the vapour should be intermitted; the patient should for certain intervals be allowed pure air, and the chloroform be resumed from time to time when there is some approach to wincing under the hands of the operator.

The value of apparatus is, that they save the chloroform, and enable the surgeon (*if* the valves work well) to regulate the dose; but no valves or machinery can be substitutes for care and common sense.

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ensure Safety in the Administration of Chloroform? By Patrick Black, M.D., 1855; Further Remarks on the Cause and Prevention of Death from Chloroform. By John Snow, M.D., Lancet of Feb. 1856.

Dr. Anstie, although he condemns the handkerchief, gives four cases in which patients were nearly killed because the apparatus did not work well.

The simplest is *Dr. Sibson's mask*. This consists of a mask, covering nose and mouth, constructed of thin flexible metal, so that it can be adjusted to a face of any form or size. It has attached to it a small cavity, within which is a piece of blotting-paper, on which the twenty minims of chloroform are dropped from time to time. Through this cavity the air is drawn in by the act of inspiration, bringing the chloroform vapour with it. A valve of vulcanized india-rubber permits the entrance of the air, but prevents its escape by the same route. Another valve opens to allow of the escape of the air that has been once breathed, but shuts during inspiration. This latter valve, if entirely turned aside, permits the atmospheric air to enter freely without any chloroform, or, if removed partially, permits it to be mixed with it in any proportion. Matthews has an improvement which allows the chloroform box to be turned in any direction, so that the chloroform can never run into the mouth.

Dr. Snow's Inhaler consists of Dr. Sibson's mask, which is connected by a long flexible tube to a double metallic bottle. The inner bottle contains the chloroform, and has proper apertures for the transmission of air. The outer bottle contains cold water, in order to provide that the vapour may be raised at an equable temperature.

Another rude but very good apparatus is made by folding a piece of very stiff paper into the shape of a fool's cap; leaving an aperture at the top. A piece of sponge is sewed to the inside of the paper near the top; and on this (first wetted with cold water) the chloroform is poured. Dr. Skinner has devised a useful inhaler consisting of a piece of thick muslin stretched on a frame.*

Messrs. Weiss have devised one inhaler, by which the quantity of chloroform and of air can be regulated; and another fixed to the operating-table, which is said to provide against waste of the vapour, and excessive doses. From Dr. Anstie's description, it does not add to the patient's safety.

If, however, any apparatus at all is to be used, it should be *Clover's*. This consists of a mouthpiece having valves to admit the fresh air at pleasure; and connected by a flexible tube to a large india-rubber air-proof bag; which the administrator hangs from his shoulders, and carries on his back. This bag is filled with air, ready impregnated with chloroform vapour in definite proportions. A bellows holding 1000 cubic inches of air is made to drive its contents through a box into which 40 minims of chloroform have been introduced by a graduated syringe; this quantity gives 45 inches of chloroform vapour, or 4½ per cent. to the air with which the bag is filled. The valves should be opened at first so that even this vapour may be further diluted.†

* Obstet. Trans., vol. iv., p. 116.

† See Notices of Surgical Instruments, by James R. Traer, Med. Times and Gaz., August 9, 1862.

The following hints may be of use to beginners:—The chloroform should not be allowed to touch the lips, or it may blister them. The patient should not be chloroformed within two hours of a full meal. This precaution may prevent the annoyance of vomiting. He should be narcotized before he is removed to the operating-table, and before he can see any preparations or knives. The humanity of this precaution, if a timid patient is to be brought into the operating theatre of an hospital, is evident. He should be taken back to bed again in a state of unconsciousness. *There should be no hurry*, because complete insensibility to pain, and absence of involuntary movement and wincing, are more safely obtained after the vapour has had time to permeate all the capillaries and benumb all the peripheral nerves. Dr. Snow makes the most valuable observation, that insensibility to pain cannot be obtained in a *very rapid* manner without a dangerous degree of narcotism of the nervous centres. The inhalation should occupy at least from four to seven minutes before the third degree of narcotism is established; and then it will usually be another minute more before the surgeon should begin—*eight minutes* altogether. The loud talking or violence of the intoxication stage is no cause of alarm; quite the reverse; it shows that the vapour has not produced a dangerous effect, and that a slight increase is necessary to produce the next degree.

At every operation the management of the chloroform should be committed to one competent person, whose duty it should be to attend to it, and nothing else, with his eye on the breathing, and his finger on the pulse.

The *class of patients* on whom chloroform acts most pleasantly and safely are women in childbirth; next, children, in whom it scarcely ever causes either mental excitement or struggling. Moreover, immunity from pain is obtained with less narcotism of the nervous centres than in adults. It does not work so well on *infants*. The very aged are long in recovering their consciousness after inhalation. The more feeble a patient is, the more quickly and pleasantly does the vapour generally act; if very strong and robust, considerable mental excitement is apt to occur in the second degree of narcotism, and struggling or rigidity of the muscles in the third. Some patients hold their breath for some seconds. In this case, the first deep inhalation should be of pure air only.

The cases in which the inhalation of chloroform is useful, comprise, in the first place, every surgical manipulation attended with pain; of which it seems not only to render the patient unconscious, but also, by preventing its effects on the mind, to neutralize its depressing power on the body. To lull the pain during operations as well as the smarting after them; to lull the pain and shock of violent injuries, and of the surgical examination and setting of fractures which follow; to facilitate the reduction of herniæ and dislocations and the passing of catheters, and to detect feigned disease; these are its chief surgical uses. But its benefits are not confined to the abolition of pain; there is great reason for hoping that it renders operations less mortal; it en-

ables the surgeon to proceed with his dissection in a more leisurely manner; it does away with the scruples of the over-modest woman, to whom the shame of exposure is worse than the pain of the knife; and it circumvents the opposition of the timid and unruly.

In *military surgery* it has special uses. "In the prolonged searches," says Dr. Macleod,* "which are sometimes necessary for the extraction of foreign bodies, it not only prevents pain, but restrains the involuntary contraction of muscles which otherwise would throw great obstacles in the way of both search and extraction. In field-practice, too, when a number of men come in quick succession during a general engagement, to be operated upon, the brave fellows who are waiting for their turn are spared the depression which the groans of their comrades under the knife would otherwise inflict upon them."

In the case of *children*, many things can be done nicely with chloroform, which could be but most ill done, if at all, without it. Take, for instance, the case of wounds of the eyelids or eyebrows, which, if not most accurately sewn up, are sure to be followed by frightful seams, or by inversion or eversion of the lids, and perpetual overflow of tears. By a little chloroform, not merely the pain and fright of the injury, and the severe smarting caused by the needle, but the struggles also, which render quickness and nicety of adaptation impossible, are done away with; the patient sleeps tranquilly during the process, and wakes composedly soon after, absolutely without any ill consequences whatever. The writer administered it day by day for a fortnight to a child of four years, who had been severely scalded, in order to prevent the screams and struggles which accompanied the dressing of the wound. No ill effects whatever resulted. The child slept during the dressing, and awoke without sickness.

But the uses of chloroform are far from being confined to the practice of surgery. In midwifery the uneasiness and spasms which attend the early stages, and the distension and rigidity of the later, together with the anxiety and fears, are so tranquillized that, although fortunate and healthy women need it not, yet those who have ever experienced the comfort of it, are never willing to forego it in another confinement. Moreover, in ordinary cases, its good effects may be obtained with the smallest doses, without scarcely passing the first or second degree of narcotism, and without the slightest danger at the time, or ill effect on mother or child afterwards.† In the operation of midwifery its effects are admirable; and not the least happy circumstance is, that it works so well with opium. In general physic its use is great; not so great, perhaps, as the writer was led to hope in preceding editions of this work. In the last edition but one we said, "In general terms, it may be said to achieve perfectly, and at once, what opium in an hour or two in doing gradually. Moreover, it has the happy property of being as

* Notes on the Surgery of the War in the Crimea. By G. H. B. Macleod, M.D., F.R.C.S., &c., Lond. 1858.

† The writer has an Essay on the Causes, Varieties, and Prevention of Pain in Labour, which he hopes to publish ere long.

quickly and entirely eliminated from the system, that there are in most cases no ill effects afterwards; none of the checked secretions for which opium is, justly or unjustly, so often blamed. Hence, in violent pain and spasms, especially in colic, in spasmodic asthma, and spasmodic cough, dyspnœa, dysuria, dysentery, dysmenorrhœa, and almost every other compound of δὸς, in hysteria and convulsions not depending on fulness of the nervous centres, this remedy may be resorted to. In the violent colic of infants, for example, the sagacious physician, instead of letting the patient shriek itself to death, whilst he is waiting for the effect of remedies, will, by this vapour, stop the pain, which is the element of danger, and remove the causes of the illness radically at his leisure."

Increased experience compels the writer to say, that although his former opinion stands good with regard to cases of sudden painful illness, in previously healthy persons, yet that chloroform is not always eliminated quickly; and that it often leaves an amount of sickness, headache, and feverishness, which are great drawbacks to its use in cancer, neuralgia, and dysmenorrhœa, cases in which the writer has tried it; and for which æther and camphor, F. 206, is to be preferred. See *Tetanus*.

Cases in which it is inapplicable.—It is generally considered better not to use chloroform in cases of extraction of cataract, in elderly persons. There are two reasons for this. First, lest the vomiting which often happens afterwards might force out the whole contents of the eyeball. But Mr. Haynes Walton has shown that this accident may be prevented if the proper amount of gentle pressure be exerted on the eyelids by means of strips of plaster. Another more serious objection, is the loss of appetite and digestion which chloroform may occasion in aged persons. In operations on the jaws, or fauces, there is no serious fear that the blood will run into the glottis and suffocate the patient, provided the patient's head be turned on one side repeatedly to let it out freely. Full narcotism should be induced before these operations, and it should be kept up as well as it can by inhalation at intervals from a sponge wetted with cold water, on which twenty minims of chloroform have been poured. The cases in which on general principles it should be given with hesitation, are those of chronic organic disease of the brain, atrophy or dilatation of the heart, and embarrassed circulation through the lungs. But since the shock of an operation is in itself extremely formidable to patients so affected, it is probable that a cautious administration of the anæsthetic might diminish the danger instead of adding to it. Epileptic patients are liable to have their fits induced by the inhalation. It should never be given to a woman without a witness. Moreover, it should never be administered by any person to himself, nor yet be used as a plaything or a luxury. If pain is bearable, and not injurious, let it be borne.

Accidents from Chloroform.—The commonest is vomiting, which, however, is of very little consequence. If it occur during the inhalation, the patient's head must be turned to one side to let the vomited matter escape. If very troublesome afterwards, a little brandy and

soda water, or an aperient, may be administered. The patient, if chilly, should be wrapped up warmly. When the patient is an adult, and particularly if old, the chloroform may not be entirely eliminated for some hours, and may occasion nausea and giddiness, and haunt the patient disagreeably with its smell and taste. Abstinence from food beforehand will diminish, but will not infallibly prevent vomiting in all persons; since this is either an eliminatory act, for the purpose of purifying the blood, like the vomiting on the day after a debauch, or else, like sea-sickness, the result of brain disturbance.

Death from Chloroform.—That a remedy so powerful should be capable of extinguishing life, follows as a matter of course from the details which we have given. The *manner* in which life is extinguished, and which has been the subject of controversy, is not always the same in different cases.

In the first place, chloroform may kill by *apnœa*, or suffocation; by interfering with the passage of the blood through the lungs; by giving the blood such a quality that the pulmonary capillaries refuse a passage to it; or by acting upon the medulla oblongata in such a way as to stop the reflex act of inspiration. This mode of death seems to occur often in the case of animals poisoned experimentally; sometimes in man. Possibly spasm of the glottis may be produced by a concentrated vapour. In such a case, the symptoms would be those of "congestion of the head and face, staring eyes, turgid veins, struggling or convulsive spasms, ineffectual efforts to expand the chest," preceded by a sense of choking, and irresistible propensity to struggle against further inhalation. After death, congestion of the lungs, and fulness of the right side of the heart would be found.*

There is a capital experiment recorded by Dr. Chapman,† in which the heart of a cat poisoned by chloroform, full and motionless, was set beating by the loss of blood which ensued from division of the aorta and pulmonary artery, and beat for an hour and a half. Hence it is evident that this heart was stopped because overloaded, and unable to force the blood through the lungs: not paralysed intrinsically.

But, *secondly*, there can be no doubt, that chloroform usually kills *man* by syncope or angina, that is, *paralysis of the heart*. And the order of phenomena is usually this:—The patient all at once raises his body and struggles, the face is noticed to be deadly pale and the limbs relaxed, blood ceases to flow from cut arteries, no pulse is felt at the wrist, the heart cannot be felt to beat, the breathing continues slowly and gaspingly for half a minute or more, then all is over.

Of deaths belonging to this category, no better example can be given than the following:—A gentleman, aged 73, with intermitting pulse, and arcus in each eye, had been chloroformed six or eight times for the purpose of undergoing lithotrity. On Dec. 4, 1851, he was again chloroformed; during the operation he exhibited considerable faintness, though he recovered himself before it was over. A few minutes after

* We quote almost verbatim from Dr. Black's very able pamphlet.
† How Chloroform Kills, Med. Times, 18th Oct. 1850.

the operation he had what was described as alarming syncope. Spite of this, the patient was chloroformed again on the 15th and 19th Dec., by Dr. Snow; whose large experience had given him no room to anticipate bad results. On Sept. 15th, 1852, there was occasion for another operation. Chloroform was again given by Dr. Snow. The patient became insensible in three or four minutes, without struggling. The operation was begun. A little of the vapour was given twice or thrice to keep up the effect. After a few minutes great paleness of lips and face were noticed; but immediately afterwards the face reddened, and the patient strained, as though he felt the operation. Hereupon, a little more vapour, largely diluted, was given. But now after two or three inspirations the breathing ceased. It seemed as though the patient were holding his breath a little, as sometimes happens; but on feeling the wrist there was *no pulse*. In a few seconds came one deep inspiration;—a few rapid and feeble pulsations of the heart were heard, which then ceased; one or two very faint inspirations followed at the interval of a quarter of a minute; then death. Cold affusion and artificial respiration were employed without avail. On inspection the heart was found large, soft, friable, and in a state of fatty degeneration.

That death in this, and in other similar cases, is brought about by paralysis of the heart, and not by suffocation, was successfully shown by the late Dr. Snow. He showed that death from pure suffocation is never so quick as death from chloroform has always been; that in cases of death from privation of air, the heart goes on beating for some few minutes after breathing has ceased; whereas, as a matter of fact, in most cases of death by chloroform, the breathing has been proved to go on up to the time the pulse stopped, and after it;—that patients have breathed it freely without struggling up to the instant of death; and that sudden paleness is a more frequent phenomenon in these cases, than turgescence of the face; although neither is incompatible with palsy of the heart. The writer may add, that in the only case in which any alarming symptoms occurred whilst he was administering chloroform, the patient complained afterwards, not of choking, but of the unmistakeable symptoms of *angina*,—fixed pain, great oppression, and feeling as of a load in the region of the heart.

Thirdly, chloroform may cause death by what the French call by the classical term *sideration*, to wit, a star-struck or blasted state of the nervous system; or, in plain English, by a sudden annihilation of the life of the brain and spinal cord. Hence the syncope may be caused by the state of the brain, and not merely by the direct action of the poison on the heart. That the poison has an injurious operation on the nervous centres, is manifest from the nature of the thing, and from the vomiting.

In giving it to young babies the writer has occasionally noticed squinting, blueness of lips, and tendency to convulsions.

In an uncertain number of cases, too, chloroform may have added to the general exhaustion, which has caused patients to sink from the shock of operations.

Yet all the accounts concur in establishing the fact that in the infinitely greater number of cases in man, it is by direct paralysis of the heart that death is produced.

A remarkable circumstance is the *apparent* capriciousness of the accident. It has been suggested that in some cases the chloroform has been impure; but of this there is no proof.

In others, that the patient's heart was weak, or in a state of oily degeneration. Yet in most cases after death the heart has been found quite sound.

In others, that the vapour was given from a handkerchief, and not with an apparatus. But the writer does not hesitate to say, that if the administrator keeps one eye on the breathing and a finger on the pulse, a handkerchief is quite as safe as an inhaler, or safer, provided that but little chloroform be put on at a time.

In other cases, again, it has been suggested that the administration was hurried, or careless. And this is no doubt true. The administrator, puzzled or annoyed by the persistence of the second or intoxication stage, gives a sudden increase, and the heart stops.

There is no peculiar *post-mortem* appearance to be found in the victims of chloroform. The blood corpuscles have been found crenated or wrinkled at their edges, but this is not universal; neither has it been shown that this appearance is confined to cases of death from chloroform. Nothing constant is remarked as to colour of the blood; nor yet as to congestion of brain, lungs, or other organs. In the earlier years of chloroform it was sought to be shown that death was due to fatty degeneration of the heart: no theory could be more convenient, nor yet more frivolous. The only inference to be drawn was, that any man might have a fatty heart without knowing it, and that therefore chloroform should never be administered without the amount of care which ought to be taken if it were certainly known that the heart were degenerate. But the truth is, that a little chloroform may be safely borne by a diseased heart; while much of it will stop the beating of the healthiest.

It must be fully admitted, too, that the conditions under which a moderate dose of vapour paralyses the heart are not known; and that, whilst a lesson of caution should be learned by us all, we have no right to cast blame on any chloroformist who may have the misfortune to lose a patient.

But the same apparent capriciousness attends most other instances of sudden death. We do not always know, why any given soft and thin heart should stop suddenly at a given time; but we do know enough to put us on our guard.

In the first place, our object should be, to obtain the greatest effect from the smallest quantity, and to avoid sudden increase. Then, to avoid all circumstances which disturb the heart; and, above all, mental agitation. The sitting posture is to be avoided. The patient should be as nearly as possible under the circumstances that induce sleep. Some good soup should be given an hour before, and some brandy just before

the operation. Account must be taken of exposure to cold and loss of blood during long operations. The air which reaches the patient should be pure; and lastly, if the pulse be very soft, and the heart's impulse feeble, and the patient subject to breathlessness on slight exertion, it will be wise to give enough merely to abate mental disquietude, without entire insensibility.

The signs of danger of narcotism from protracted inhalation are, (*a*) *breathing* slow, or shallow and quick and feeble, or intermittent; (*b*) *pupil* dilating; (*c*) *pulse* very feeble or intermittent. The remedies are to take away the chloroform, open doors and windows, and dash cold water in the face, and give stimulants by mouth or rectum. But supposing that symptoms of *heart-failure* show themselves? Then, in addition, pull the tongue forwards, so as to unstop the glottis; use artificial respiration by Silvester's method; or by inflating the lungs from mouth to mouth, and emptying them by pressure on the thorax; to apply one pole of a galvanic apparatus to the neck; another to the diaphragm or to the heart itself, running in a fine needle; (galvanism, be it observed, should be used gently, and not long together). If breathing be restored, the rest is a matter of time and stimulants. Dr. Chapman's experiment, in which the distended heart of an animal was set beating by loss of blood, suggests the propriety of opening the jugular vein, and letting some blood flow, especially if the face be turgid. Dr. Sibson suggested to the author, in conversation, the expediency of injecting into a vein, towards the heart, some stimulating liquid. The heart will beat a long time in warm water: and the injection of warm water with a little salt, or of pure fresh blood from the veins of a bystander, would be a most desirable experiment.

The number of well-authenticated cases of death from chloroform collected by the Committee of the Royal Medico-Chirurgical Society is 123; which probably is not more than two-thirds of those which have actually occurred. It is an abuse of statistics to attempt from any data yet at our command to estimate the amount of danger run by any individual patient. This must be a result of the quality of the chloroform, of the quantity used in a given time, of the mental and bodily condition of the patient, of the care and skill of the chloroformist, and of the patience of the surgeon who has to operate; for if he be in a hurry, and pull out his watch, and if the chloroformist take the hint, and push the vapour suddenly, the patient is in imminent risk.

Has chloroform, on the whole, increased the mortality of operations? Dr. James Arnott asserted that the mortality of amputations has increased from 21 to 34 per cent. since the introduction of chloroform, and in consequence of the use of it; but the inquiries of the Committee of the Royal Medico-Chirurgical Society have confirmed the conclusions previously arrived at by Mr. Fenwick and Mr. Coates, that the mortality of operations has not been increased.

CHLOROFORM COMPARED WITH OTHER ANÆSTHETICS.—It remains to be seen whether some substitute can be found for chloroform, or whether a combination of it with other narcotics may be equally

effectual and more safe. *Ether* is much less pleasant than chloroform, more irritating to the air-passages, and more apt to be followed by headache and other unpleasant symptoms, of which the persistent taste and smell of it in the breath are not the least. It is less rapid in its action, and therefore less convenient in practice; but it has this important property, that it seems not only not to depress, but to exalt the action of the heart, even when administered for a considerable time; in fact, if it kill, it is by suspension of the breathing, and not by palsy of the heart. It is said to produce complete muscular relaxation more perfectly than chloroform, so that it is perhaps preferable in cases of hernia, dislocation, and spasm. It would be proper to use ether, therefore, in cases in which there is any doubt of the heart's soundness. The writer generally uses a combination of it with chloroform in equal proportions in midwifery; but perhaps a mixture of one part of alcohol, two of chloroform, and three of ether, proposed by Dr. G. Harley, is the most advantageous, as it evaporates equally. The *Dutch liquid*, or compound of chlorine and olefiant gas, so called because discovered by the Dutch chemists in 1795, resembles chloroform in its general effects, and is only about one-half so powerful or rapid in its action. It is not easy to procure. A mixture of equal parts of chloroform and alcohol has caused death in America. *Amylene*, a liquid hydrocarbon, was used by Dr. Snow in 238 cases: its anæsthetic powers were satisfactory, and it caused vomiting in two only out of the 238 cases, although chloroform caused it in 22 per cent. But its odour is abominable, and it destroyed life in two out of the 238 cases. *Bisulphuret of carbon* is a powerful, but uncertain and disagreeable agent.

Dr. H. Bigelow, of Boston, removed a breast, with the aid of sixty quarts of nitrous oxide gas, "consumed during six minutes, and producing a most tranquil and complete insensibility."*

There is a compound, F. 206, which the writer constantly prescribes in cases in which a strong narcotic stimulant is desirable. Two drachms of camphor dissolved in an ounce of ether form a liquid, of which a little may be put on a handkerchief, and inhaled in nervous headaches, brow ague and other forms of neuralgia, colic, uterine cramp during pregnancy, &c.

MEANS OF PRODUCING LOCAL ANÆSTHESIA.—Something is desired which shall produce perfect insensibility of the part to be operated on, and yet leave the brain in possession of its faculties. Very many experiments to this end have been made by Dr. Simpson, who has found that the strongest preparations of opium, aconite, belladonna, tobacco, and Indian hemp produce no appreciable insensibility when applied to the human skin; and although prussic acid rubbed on the gums, and the vapour of chloroform applied continuously to the skin, produce some numbness, yet still they are not sufficient to render a cutting

* See Med. Chir. Trans., vol. xlvii.; Chapman, Westminster Review, Jan. 1859; Anstie, *op. cit.*; Dr. Kidd on Anæsthetics; and Papers in Med. Journals, 1863.

operation, or the extraction of teeth, painless. Galvanism and electricity have been tried, and failed; and a combination of narcotic applications with galvanism has been tried by Dr. Richardson with very unsatisfactory results. Creosote soothes decayed teeth, and carbonic acid the surface of ulcers. A small quantity of chloroform put into a spoon, and evaporated over a candle, will allay the pain of an ulcer. But the most efficient local anæsthetic we are at present acquainted with, is

INTENSE COLD, the properties of which have been explored by Dr. James Arnott. The writer has witnessed his mode of applying it, and has applied it himself, thus:—

The operator must be provided with about a quarter of a pound of ice, broken quite fine, which may be effected by putting it into a small canvas bag, and using a mallet or flat iron. "The pounded ice having been placed on a large sheet of paper, any loosely cohering particles may be separated by a paper-folder, and the unreduced larger bits removed. Beside it, on the paper, about half its weight of powdered common salt is placed, and they are then thoroughly and quickly mixed together, either by the folder while on the paper, or by stirring them in a gutta-percha, or other non-conducting vessel. If the mixture be not quickly made, the extreme cold of part of it may again freeze other parts of it into lumps." There must be in readiness a small net of thin gauze, into which the mixture is put; and as soon, says Dr. Arnott, as the action of the salt upon the ice appears by the dripping of the brine, it is ready for use. The part to be benumbed should be held horizontally, and the net should be laid over it; but it is as well to raise the net once in every three or four minutes, in order to watch the effects, and render them equal. A sponge should be held so as to catch the briny fluid that escapes. The process requires a little nicety, which one or two trials will give.

If it be nicely performed, it makes the skin immediately pale and benumbed, but gives no disagreeable sensation. This effect gradually increases, till the skin is shrunk, of a peculiar tallowy corpse-like paleness, perfectly insensible, and stiffish. Dr. Arnott believes that, by protracted application of the ice, the fat is congealed. The process, as the author can testify, is rapid and painless; and when the effects of the cold have passed off, if the part be bathed with cold or iced water, or covered with a bladder containing it, there will be very little tingling or inflammation; possibly a little redness.

Unquestionably, if the application be continued for an unreasonably long time—say for an hour or two—or if heat be incautiously applied too soon afterwards, the same effects may ensue as those which we have described at p. 165, under the head of frost-bite, particularly if the patient be of a bad or weakly constitution. But the moderate and judicious use of cold is followed by no ill consequence whatever, and it seems to promote the process of healing.

As an anæsthetic remedy, it appears amply sufficient, and well adapted for most of the minor operations, such as those on small tumours, abscesses, warts, inverted toe-nails, fistula, piles, varicose

veins, application of the actual cautery, formation of issues, and the like. For extensive and deep operations, and those in which perfect quiet is requisite, it is insufficient.

Besides its use as an anæsthetic before operations, it has been employed to check the growth of cancer and nævus, and to assuage the pain of boils, carbuncle, gout and neuralgia. The writer has used it in whitlow, and it gave relief to the pain, but did not hinder the formation of matter.

For the application of the freezing mixture to ulcerated surfaces, a fine india-rubber bag or gut may be used. Dentists employ a modification of a process invented by Dr. James Arnott, for passing a stream of water of any temperature through a membranous bag over a diseased part. In the apartment over the operating-room is an apparatus by which at first a stream of water of the temperature of the body, and then a saline solution, gradually cooled down to about 15° of Fahrenheit, or lower, is made to pass through an india-rubber tube. At one part of this tube there is inserted a tube of the thinnest possible india-rubber, which is wrapped around the condemned tooth and the adjoining gum, and through which the cold current acts upon those parts. The writer has seen the process conducted by Mr. Quinton, and can testify that the success of it was complete; that is to say, it occasioned no pain itself, and it allowed a tooth to be pulled out without any. The gum was blanched, and did not bleed, but the tooth, and inside of the socket did. Rinsing the mouth for some time with cold water takes away all unpleasant consequences. The writer's objection to the process is, that it is more troublesome than the result is worth; especially if many teeth are to be operated on.*

MESMERISM.—There is no doubt but that the manœuvres which are called mesmeric passes, if practised long enough upon susceptible persons, are capable of producing a kind of cataleptic condition accompanied with insensibility to external impressions, and that in this state surgical operations have, in many instances, especially amongst the natives of India, been performed without the patient's consciousness. But ample objections to mesmerism, as a medical agent, may be gathered from the works of its advocates. The writer has most carefully analysed the works of Dr. Esdaile, a surgeon of great experience in India; in which it is asserted, 1st, as to the *nature* of mesmerism:—"That it is the transmission of nervous matter to the brain of the patient from the brain of the agent, through the nerves of the latter." Which is nowhere proved. 2ndly, as to the *process*:—That it consists in touching some part of the patient's body, breathing on it, and making stroking movements, called *passes;* but it is alleged that the *intention* or will of the operator is the chief agent, no matter how the passes are made. 3rdly, as to the *effects*:—That they consist of various degrees of insen-

* See Dr. James Arnott's pamphlet on benumbing cold as a preventive of pain and inflammation from surgical operations, with minute directions for use, 1854. Pamphlets by Mr. Quinton, Mr. Blundell, and others on Anæsthetic Dentistry. Mr. Butcher, in his Observations on Hare-Lip, Dublin, 1856, speaks briefly on the use of cold, but complains that it causes pain in the case of children with hare-lip; as much pain as the operation itself.

sibility, delirium, and muscular rigidity; during which it is asserted that the patient is completely under the control of the operator; his bodily sensations, his actions, and his very thoughts being exactly those which the mesmerizer may *will* his passive victim to experience. We do not mention certain other alleged phenomena, such as the power of seeing without eyes, of prophesying, &c. &c., which do not concern us.

On the other hand, there is the admission, 4thly, that mesmerism is only one of six powers, each capable of producing the same effects on mind and body; the other five being—religious fanaticism—exhaustion of the brain by long contemplation—exhaustion of any one organ of sense—narcotic medicines—and last, not least, *hysteria*. Where so many known causes exist to explain the phenomena of mesmerism, it seems unnecessary, to say the least, to go out of our way to imagine a transmission of nervous power. It is confessed further by Dr. Esdaile, 5thly, that all the *mesmeric* phenomena, like the *hysteric*, if once induced, may occur in paroxysms, without any mesmeric passes, whenever *willed* by the patient, especially if the nervous centres have been rendered morbidly sensitive by the mesmeric process.

If these things be properly weighed, and if the reader consider further that the mesmeric state (or in plain English hysterical catalepsy), is one which cannot be induced in persons of sound vigorous mind; that, if free from all objection, it could seldom be available at the time and place requisite; and that it is confessed that a person susceptible of it is, to use Dr. Esdaile's words, "at the mercy of any foolish or unprincipled person,"—he will agree with the writer, that it has no claim to be received into the rank of therapeutical agents. "It is often," says Dr. Esdaile, "very difficult and laborious to excite the mesmeric action in the constitution; but being once felt, a very slight recurrence to the original process will often bring on the mesmeric paroxysm; and if the excitement of the nervous system is kept up by frequent mesmerizing, an independent diseased action is set up in the constitution, we have, in fact, inoculated the system with a nervous disease, acting spontaneously, and obeying natural laws we do not understand."*

CHAPTER III.

THE MINOR OPERATIONS.

I. EXTIRPATION OF TUMOURS.—A different proceeding is to be adopted in the case of cancer and of other growths. In the former it may be necessary to remove a portion of skin by two semi-elliptical incisions, if it appear to be contaminated by the diseased growth. But in extirpating wens or fatty or fibrous tumours, however large, it is a general rule not to remove any of the skin, unless it is much inflamed or ulcerated, or so entirely adherent to the tumour that its separation

* Esdaile on Natural and Mesmeric Clairvoyance, Lond. 1852, p. 235; Introduction of Mesmerism *into the Hospitals* of India, 1852, p. 42; Brierre de Boismont *on Hallucinations, by Hulme*, p. 216.

would be very tedious and difficult. Again, in the former case, it is necessary to cut quite wide of the diseased mass, and remove plenty of

the surrounding tissue; in the latter case, the incisions should be carried through the cellular cyst of the tumour. Then after a free incision through the cyst, the tumour may often be squeezed or twisted out, and its connections be torn, with the assistance of one or two touches of the knife.

In all cases it is a better plan (unless the tumour is exceedingly large) to carry the dissection at once boldly to the deepest part where the largest vessels enter than to tie the different branches as they are divided, by which means some vessels may perhaps be tied more than once. Again, it is requisite in every case that the extirpation be complete, because if the smallest portion is left, it may become the nucleus of a fresh growth. If, therefore, it is found that there is any portion of a tumour which cannot be cut out without fear of dangerous hæmorrhage, a double ligature should be passed through its base

and be tied tightly on each side of it. The *serrefines* of wire and the small forceps here depicted, which hold on by their own elasticity, may be of service to check bleeding in extensive operations.

II. THE ECRASEUR.—As the act of biting the umbilical cord by an animal is to the cut of the knife or scissors, so is the effect of this instrument to that of the knife. It is a machine, consisting of a fine chain (perhaps wire or whipcord), and of a screw or rack for tightening it; so that when the chain is made to surround any tumour it is made slowly to crush or bite its way through. The advantage of the instrument is, that it causes little or no bleeding. The cases in which it is applicable are those of cancer of the tongue, piles, vascular tumours, polypi and other tumours of the womb and rectum, and the division of the pedicle of an ovarian cyst. In the case of a tumour with a pedicle, its application is easy; if the mass is solid, or it is desired to extirpate a portion of the side of the tongue, for example, the chain may be

* A well-constructed forceps by Matthews, for operations and resections. The teeth hold like those of the shark, on which they are modelled.

passed through the centre and be made to cut one line of a V incision first, and the other afterwards. Or two instruments may be used together. The écraseur was invented by M. Chassaignac, and introduced into England by the late lamented Mr. Price.

III. VENÆSECTION at the bend of the arm should always, if possible, be performed in the median-cephalic vein. A ligature being placed a little above the elbow (but not tightly enough to stop the pulse at the wrist), the operator takes the forearm in his hand, places his thumb on the vein a little below the intended puncture, and then (using the right hand for the right arm, and *vice versâ*) pushes the lancet obliquely into the vein, and makes it cut its way directly outwards. When sufficient blood has been taken, the surgeon should untie the ligature above the elbow, and place his thumb on the bleeding aperture. Next he should put a little bit of lint on the wound, and secure that with a strip of plaster, only removing his thumb sufficiently to admit of the application. Then he should remove his thumb enough to put on a little square compress of linen, and over that the middle of a bandage. This is to be passed round the elbow in the form of a figure of 8, and the two ends are to be crossed and turned backwards over the compress. The next figure (p. 728) is intended to show the way in which the surgeon should grasp the arm, and keep his thumb over the bleeding aperture till the bandage is secured.

The jugular vein is sometimes opened in cases of apoplexy in adults, and in children if the veins at the elbow are hidden by fat. The patient, if a child, being laid in a nurse's lap,

* This cut shows the veins of the bend of the elbow, together with the relation of the brachial artery to the median basilic vein.

with his head towards the surgeon, the latter puts his left thumb on the vein a little above the clavicle, and then opens it with a lancet,

cutting towards the thumb, and in a direction downwards and inwards, so that the incision may cross the fibres of the platysma. When blood enough has been taken, the wound should be closed with lint and plaster, and not till then should the thumb be removed. In performing the operation of venæsection care must be taken that the opening in the skin and fascia is *directly over*, and rather larger than that in the vein, otherwise an accumulation of blood takes place under the skin, causing a tumour (thrombus) which by pressure upon the vein may stop the flow of blood. This is especially the case in venæsection of the jugular if the fibres of the platysma are not properly divided.

The veins in the leg, scrotum, or neighbourhood of the eye or ear, can readily be opened in the same manner, instead of the ordinary mode of venæsection, or leeching, or cupping.

Abscess in the areolar tissue, inflammation under the fascia, phlebitis, neuralgia, varicose aneurysm, and aneurysmal varix, are occasional ill consequences of venæsection.

IV. ARTERIOTOMY.—The temporal artery should be opened above the outer angle of the eyebrow—not just above the zygoma. The surgeon feels for the largest branch—usually the anterior—steadies it with two fingers, one placed above, and the other below, the intended puncture—then pushes in the lancet in the same manner as in venæsection. The incision should be directed across the vessel, and should cut it about half through. When sufficient blood has flowed, the best plan is to introduce the lancet, and cut the vessel completely across, so that its ends may retract. A firm graduated compress should then be applied, and be confined with a bandage passing round the

head; and some degree of pressure should be kept up on the wound for a week or ten days. Any subsequent bleeding or spurious aneurysm must be treated by completely dividing the artery, if it has not been done already, and by pressure; but if the wound is much inflamed or ulcerated, so as not to admit of pressure, a transverse incision should be made on each side of it, and the artery be tied in both places.

V. CUPPING.—The patient being placed in a comfortable position, with towels arranged so that his clothes may not be soiled by the blood, and being moreover protected from cold, so that the flow of blood to the surface may not be checked, and the operator having his scarificator, glasses, torch, spirits of wine, lighted candle, hot water, and sponge conveniently arranged on a table close by; the first thing is to sponge the skin well with hot water, so as to make it somewhat vascular. The operator next dries it with a warm towel, and adapts his glasses to the part. Their number must depend on the quantity of blood to be taken—from three to five ounces is a fair calculation for each glass. In the next place, he dips the torch in the spirit, sets it on fire, introduces it for half a second into one of the glasses, and immediately claps the latter on the skin—and the same with the other glasses in succession. As soon as the skin has become red and swollen, he charges the scarificator, and takes it between his right forefinger and thumb, at the same time holding the lighted torch between the little and ring fingers of the same hand. He then detaches one glass by insinuating the nail of his left forefinger under its edge—instantly discharges the scarificator on the swollen skin, and as expeditiously as possible introduces the torch into the glass and applies it again. The same process is repeated with the other glasses. When they become tolerably full, or the blood begins to coagulate in them, they must be detached in succession and reapplied, if blood enough has not been taken—and when the operation is finished, the wounds should be closed with lint and plaster. There are several points connected with this operation that require notice. In the first place, the glasses must not be exhausted too much; if they are, the pressure of their rims will occasion severe pain—the blood will not flow—and the operation will very probably be followed by a considerable ecchymosis. Secondly, the position of the glasses must be slightly varied each time they are applied, so that their edges may not again press on the same circle of skin. Thirdly, the expediency of not burning the patient need scarcely be hinted at. Fourthly, in taking off the glasses, the upper part of each should be detached first, so that the blood may not escape. Lastly, the length of the scarificators must be adjusted to the thickness of the skin; for if the incisions are too deep, the fat will protrude through them, and prevent the flow of blood. The direction of the incisions should correspond to the course of the muscular fibres beneath; but this is of no great consequence. For *cupping on the temples* smaller glasses and scarificators are employed. A branch of the temporal artery is generally wounded, and the flow of blood may be expedited by slightly lifting the lower part of the rim of the glass.

Pressure should be kept up on the wounds for some days afterwards, in order to prevent secondary hæmorrhage or false aneurysm.*

VI. TRANSFUSION OF BLOOD.—This is an operation which may be performed in two sets of cases. In the first place, whenever death seems imminent from profuse loss of blood; especially after flooding in labour; after operations, wounds, and injuries of all kinds, and the bursting of varicose veins. In every such case, it is the surgeon's positive duty to perform this operation. Secondly, there are some cases in which death is creeping on from slow starvation through disease, such as cases of cancer, and of any other organic disease that is causing exhaustion, in which it may be a question to be decided by the patient whether the attempt shall be made to prolong life for a few days or even hours. Besides these cases, the surgeon may think it expedient in cholera, to inject water containing the saline constituents of the serum.

In flooding and other sudden accidents it will almost certainly happen that no elaborate apparatus is within reach, and the surgeon will have to use whatever he can lay his hands on. It is consolatory therefore to know that most of the successful cases of transfusion have been performed with common pewter or brass syringes.

The operator must of course find some healthy person who is charitable enough to spare some of his blood. Then supposing that he has nothing but a common syringe, he must immerse it in hot water, and thoroughly rinse it out so as to cleanse it from dirt.

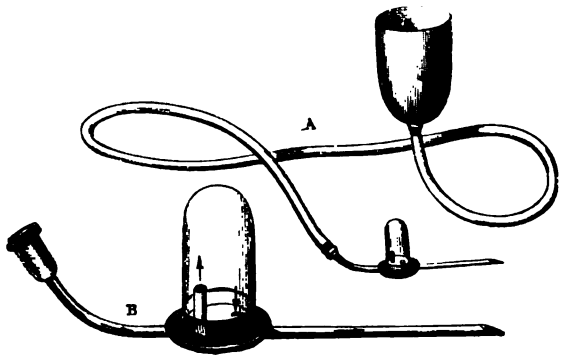
The next thing is to open a vein in the patient's arm, or if there is no prominent vein there, in the leg. It may, if large, be opened with a lancet, as in venæsection, and then a probe be passed into it, to serve as a director for the nozzle of the syringe. The probe ought to pass up freely along the canal of the vein. If there is any difficulty, an incision an inch and a half long should be made over a vein, which should be gently raised on a probe passed under it, and be opened sufficiently.

The operator next takes out the piston of the syringe. Then, the arm of the person who is to give the blood having been, meanwhile, bound up, he opens a vein freely, and catches the blood in the syringe, closing the nozzle with one forefinger. When he has taken as much blood as the syringe will hold, he desires the blood-giver to put his finger on the wound to stop the blood; then puts in the piston, holds the syringe with the nozzle upwards, presses the piston so that all air and a little blood may escape, then, whilst a little blood is escaping, he inserts the nozzle into the vein, and gently drives in the blood. Three or four ounces may be injected twice, or thrice, at intervals, according to the effect produced.

If the surgeon has time for choice of instruments and for a deliberate

* Messrs. Weiss have shown the writer a French instrument, *ventouse*, as it is called, in which an elastic suction-bottle, with valves, is used to exhaust the air. It appears to be very efficient, and much less troublesome than the torch and spirit of wine apparatus, as the amount of suction can be regulated with the greatest nicety.

operation, he may use the very ingenious apparatus invented by Mr. Whitehouse, of Brighton, constructed by Weiss, and here depicted. It



consists of a cup of glass or of metal plated, a flexible tube A, and a tube B, which is to be inserted into the vein. This last has an *air-trap* connected with it, so constructed that any bubbles of air would be detained in it, and be rendered visible to the operator. The blood is received into the cup, and allowed to fill the flexible tube and air-trap (which is emptied of air by being turned upside down), then the nozzle can be inserted into the vein. By raising the cup the force of the stream is increased, and it can be stopped in a moment by the finger and thumb of the operator.*

VII. ACUPUNCTURE is easily performed by running in five or six needles with a rotatory motion. It is certainly very efficacious in some cases of neuralgia; but it is by no means easy to explain its operation. Acupuncture is also resorted to in anasarca, when the skin is much distended; and we have spoken of its utility in hydrocele, ganglion, hydrothorax, and ascites, for the purpose of permitting the serum to exude into the cellular tissue.

VIII. ISSUES may be made by caustic, or by incision, or by the actual cautery. The first may be made either by rubbing a portion of skin of the requisite extent with the potassa fusa, or by making a paste with equal parts of the potass and soft soap, and laying it on the skin till the latter is converted into a black slough. The parts immediately around the issue should be protected with several layers of stick-

* The writer has to thank Mr. Whitehouse for much valuable information on the subject of this instrument. It may be mentioned that about the year 1836, Mr. Philpot, his partner, performed transfusion successfully with a common pewter syringe. Mr. Whitehouse recommends that the blood should be *defibrinated*, by being beaten up with a fork, before it is injected, so as to avoid embarrassment with clots.

ing-plaster. After the application of the caustic, the part should be poulticed till the slough separates, and then the sore may be prevented from healing, either by binding several peas firmly on its surface, or by touching it occasionally with the caustic. The second species of issue is made by pinching up the skin, and slitting it up with a lancet, and then introducing some peas to prevent it from healing. It may be remarked, that issues should never be made over projecting points of bones, nor over the bellies of muscles, for they might degenerate into most obstinate sores. Thus, for diseased vertebræ, the issues should be made between the spinous and transverse processes; for diseased hip, *behind* the great trochanter, and not over it; for diseased knee, just below the inner tuberosity of the tibia. Issues, if indolent or irritable, should be healed up. They are only of use, says Mr. Vincent, when the actions carried on in them are vigorous and healthy.

IX. THE ACTUAL CAUTERY is certainly a very efficient, and it is very far from being the most painful, manner of effecting counter-irritation. On the contrary, its effects are speedy, and not attended with very much suffering. It is easily effected by means of an iron rod with a knob of the size and shape of an olive at one end of it, and a wooden handle at the other. The knob being heated red hot, is rubbed on the skin so as to make two or three blackened lines about half an inch wide, and an inch asunder. Then the cold-water dressing or a poultice may be applied till the shallow eschars separate; and it appears to be better to keep the sores open by touching them occasionally with the cautery, than by the ordinary irritating dressings. We have spoken in more than one place of the efficacy of the cautery for closing fissures and fistulæ. The surgeon will require instruments of various sizes and shapes for these purposes.

Marshall's galvanic cautery is a very convenient instrument for cauterizing the interior of sinuses, or fungous granulations. A current from a galvanic battery of half-a-dozen cells is passed along the metallic rods and through the handle; the rods are isolated by an intermediate strip of ivory, and the current passes through the wire at the end, raising it to an intense heat. The wire can be arranged in any convenient shape. There are other modifications, some having an apparatus in the handle for making and breaking contact at will.

X. SETONS are introduced by pinching up a fold of the skin, and pushing a needle through it armed with a skein of silk or cotton, or a long flat piece of india-rubber. As soon as one or two inches of the thread are brought through, the needle is cut off. A fresh portion of

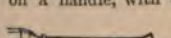
the thread is to be pulled through the wound every day, so as to keep up a constant irritation and discharge. If the discharge is insufficient, the thread may be covered with some irritating ointment before it is drawn under the skin.

Instead of threads, a small Chassaignac's drainage-tube may be used (see p. 59).

XI. THE MOXA is a peculiar method of counter-irritation long practised in the East, and occasionally employed in Europe, for the relief of chronic nervous and rheumatic pains, and for chronic diseases of the joints. One or more small cones, formed of the fine fibres of the *Artemisia chinensis*, or of some other porous vegetable substance—such as German tinder, or linen impregnated with nitre, are placed on the skin over the affected part, and then are set on fire and allowed to burn away so as to form a superficial eschar. The surrounding skin must be protected by a piece of wet rag, with a hole in it for the moxa.

It is convenient sometimes to use the moxa as a rubefacient or vesicant, and not as a cauterant. A roll of German tinder ignited may be held with dressing forceps at a little distance from the skin, the surgeon at the same time blowing upon it with a blowpipe till the skin becomes red.

XII. VACCINATION.—The matter should be taken on the seventh or eighth day, before an inflamed areola is spread around the vesicle; and it should be *lymph*, clear and transparent, not purulent. The operator with the point of a lancet—a sharp-pointed tenotomy knife is better—should puncture, scratch, or abrade the cuticle in five spots, on the outside of the left arm below the shoulder: each spot may be the size of O, and the five may be arranged in the form of a cross. Then taking a drop of clear lymph on the point of the knife, he inserts it into one of the spots, taking care that the abraded skin absorbs it; and so with the others. The lymph should be applied directly from one child to another, and should not be carried about on points or lancets. But if the lymph for the first patient is on *points*, the surgeon should hold them in the steam of warm water so as to liquefy it, and then wipe one on each abraded spot. Special instruments, such as Spratley's, consisting of a grooved needle, mounted on a handle, with an angular



point, guarded by a stop to prevent its going too deep, are not so good as a clean sharp-pointed knife or lancet. To preserve lymph safely, it should be *dried*, not kept moist in tubes or bottles.

XIII. ELECTRICITY AND GALVANISM.—In certain cases of defective circulation and nervous influence; when the thigh is weakened and benumbed after sciatica; in cases of atrophy of the extremities after fever; when the extensors are paralyzed from long disuse, as after disease of joints; in deficient menstruation; in loss of voice from

relaxation of the mucous membrane of the fauces; in hysterical neuralgia,—these agents may be resorted to. Electricity is used by passing *slight* shocks from a Leyden jar or by putting the patient on an insulating stool in connexion with the prime conductor, and taking sparks from him. Galvanism is most applicable in asphyxia from poisoning or hanging, when the affusion of cold water and other stimulants fail to excite the action of respiration. The best method is, to place one wire in the nape of the neck and the other at the pit of the stomach; or, if the sensibility is so feeble that this fails to take effect, a needle may be inserted deeply between the eighth and ninth ribs on either side, so as to reach the diaphragm, and the current be passed between them. The surgeon may employ a *constant* current, from a battery; or the interrupted, to and fro series of small shocks, known as Faradization. The latter is the proper form for *exciting* the heart or diaphragm. It may be obtained from a large single-cell battery on Smee's or Daniell's principle, with a coil wound round a piece of soft iron, which is thereby converted into a temporary magnet, and with a contrivance for interrupting the circuit, and giving a stream of gentle shocks. Or from a magneto-galvanic battery, in which the force of a permanent magnet is employed to create a stream of shocks by a rotatory apparatus.*

XIV. GALVANO-PUNCTURE.—In obstinate neuralgia it is a good plan to insert two needles deeply, at two points in the course of the nerve, and to pass a galvanic current through them.

CHAPTER IV.

SLINGS AND BANDAGING.

I. SLINGS.—The importance of a proper application of these supports to the extremities is often overlooked.

For the upper extremity three kinds of sling are appropriate for injuries of the different bones. A long, soft, stout silk handkerchief should be chosen if possible. If the *upper arm* be broken or injured the sling should support the wrist only. There should be no upward pressure upon the elbow, for that would tend to displace the broken fragments and shorten the arm. In fracture of the *fore-arm*, the handkerchief should, on the contrary, be spread out along the arm from the fingers to the elbow, so as to give equal support in its whole extent. In fracture of the clavicle, one end of the handkerchief (the outer) should pass obliquely across the back of the patient, and be tied to the front end over the opposite shoulder, hugging the elbow closely and drawing it well forward in front of the chest, at the same time covering the hand and holding it well up towards the opposite shoulder, so as to lift up the shoulder well and push it backward.

The foot may be slung by means of a long and broad strip of calico passing in a loop round the neck, after the manner of a clergyman's

* Consult Dr. Althaus on Paralysis, Neuralgia, and their Treatment, by Galvanisation and Faradisation, &c.; and Harry William Lobb on Galvanism, and on Treatment of Paralysis, &c.

stole, and fastened by the ends, being sewn on each side of a slipper. By this means the patient is enabled to move on crutches with little pain and danger to the injured part.

II. BANDAGES usually consist of strips of linen, calico, or flannel, varying in breadth from one to three, five, or more inches, and in length from one to six, eight, or twelve yards. Sometimes they are made of india-rubber web, or of a substance like stockings; but, for most purposes, stout unbleached calico, or thin fine calico, will answer. They are generally rolled up longitudinally for use, and hence have received the name of *rollers*. Besides the simple roller, there are many compound bandages, as the T bandage, and the many-tailed bandage (described at p. 286); but the latter are not now much in use, and, like other special bandages, are generally prepared by professed bandage-makers. Lastly, bandages may often be made out of handkerchiefs, or square pieces of linen.

III. The chief uses of bandages are, 1st, to keep on dressings, to protect a diseased part from injury, and put some little restraint upon its motions; 2ndly, to afford a support to relaxed muscles, ligaments, and vessels. Deprive any part of its normal support, and varicose veins and dropsical effusions are sure to occur; and conversely many œdematous and other chronic swellings of the limbs and joints may often be cured by the proper application of bandages alone.

IV. THE ROLLER.—In applying this to any limb, the surgeon should hold it as represented at p. 72, or in the next figure but one, and should pass it from one hand to the other as he encircles the limb with it. He should begin at the extremity of the limb, applying it most tightly there, and a very little more loosely as it ascends. He should unfold very little of it at a time, and should make each fold overlap about a third of the previous one. When the limb increases in size, he must turn the bandage on itself after the manner depicted in the cuts.

V. BANDAGE FOR THE FINGER.—This is a simple strip of linen,

that may be wound round the finger a few times with the requisite tightness. We introduce the figure in order to show how to fasten it.

neatly without pins or stitches, by merely splitting up the end of the bandage into two tails, which may be turned opposite ways round the finger, and be tied in a bow. This is a convenient way of keeping dressings on the penis, unless sticking-plaster is used, which is better.

VI. For the Hand.—A bandage about two inches wide may be

passed in a figure of 8 round the hand and wrist, excluding the thumb, and may be finished by one or two circular turns round the wrist.

VII. For the Fore-arm.—After applying it about the hand and wrist as just described, carry it up the fore-arm, and in every turn fold or *reverse* the bandage sharply and smoothly back upon itself, in such a way that it may lie on the limb without creases.

VIII. For the Foot.—Let the roller be first passed round the metatarsus, and then be carried up round the ankle, and back again round the foot exactly as depicted at p. 72. The bandage should always be brought up on the inner side of the instep, as there shown, in order to support the arch of the foot. Sometimes it is necessary to cover the heel entirely with the bandage. This can only be neatly accomplished

by careful practice on the living subject, under competent instruction and example.

IX. For the Leg.—After the foot and ankle have been well enveloped, let the bandage be carried up the leg, and be turned sharp (*reversed*) on itself on the calf, in order that it may lie closely, and the folds not be separated. Each turn should overlap the preceding for two-thirds of its breadth.

X. For the Knee.—To support the knee, in ordinary cases, a bandage may be passed round it in a figure-of-8 form, excluding the patella. If that bone is to be covered, the bandage must be passed lightly over it afterwards several times, making turns when necessary to procure smoothness.

XI. Four-tailed Knee Bandage.—When it is merely wished to keep on dressings, or to give slight support, the four-tailed bandage devised by Dr. Westmacott may be used. A piece of linen a yard and a half long, and eight or nine inches wide, is split up in the middle at each end to within a few inches of the centre. The centre being then

placed on the patella, the four tails are brought under the knee, crossed, and tied two and two.

XII. For the Groin.—Having first taken a turn or two round the upper part of the thigh to secure the end of the roller, the dresser

should pass obliquely across the lower part of the abdomen, and round

the opposite ilium. Then, passing it straight across the back, bring it in front of the affected groin, then round the back of the thigh, next

round the abdomen again; and so on in a figure-of-8 form, with the folds crossing each other over the groin.

XIII. For the Axilla.—In order to keep on dressings or poultices, &c., put the centre of a common handkerchief folded cornerwise under the axilla, cross it over the shoulder, and carry the ends one before, the other behind, the chest, to tie under the opposite axillai (p. 739).*

XIV. For the Head.—A roller having been carried horizontally round the forehead and occiput, and secured by a stitch, let it be carried vertically over the head and under the chin. At the point of crossing on either side let it be secured by a stitch.

XV. Four-tailed Head Bandage.—A four-tailed bandage having been prepared as directed for the patella, and the centre of it having been placed on the top of the head, inclining either to the front or the back, as circumstances may require, two of the tails may be car-

* Copied from Smith's Minor Surgery, Philadelphia, 1843.

ried back round under the occiput, and be either tied there or be brought round the neck; and the other two be tied under the chin.

In bandaging the head, care should always be taken to comb the hair so that it may lie smoothly and comfortably; and likewise to arrange the bandages so that the pressure may tell exactly where it is required.

XVI. Bandage for the Perinæum.—This consists of a circular

girth buckled firmly round the pelvis; and of a piece that descends perpendicularly, and that is provided with a pad, formed of pieces of

flannel, covered with oiled skin, intended to press on the perinæum. The perpendicular piece is divided to enclose the scrotum, or labia, and lastly, is brought up in two portions to be attached to the circular girth in front. The pad must be made capable of being slipped backwards or forwards on the straight strap, so that it may be made to bear with nicety on the exact spot required. The circular girth may be kept up in its proper place by means of a pair of braces passing over the shoulders. This bandage is highly useful in prolapsus ani; and in prolapsus uteri from relaxation of the vagina; in which firm pressure on the perinæum gives the greatest possible comfort. A good substitute for it is found in a T bandage made of a piece of broad roller. The transverse piece is tied round the waist, and the vertical slit up half way in front is fastened

on each side to the front of the transverse piece. This bandage may thus be made to support a pad, either for the rectum or the uterus and vagina, or a poultice or other application to the male perinæum.*

CHAPTER V.

OPERATIONS FOR TYING ARTERIES.

SECTION I.—THE CAROTIDS, LINGUAL AND FACIAL.

I. THE COMMON CAROTID ARTERY of either side, follows a course as nearly as possible represented by a line drawn from the sterno-clavicular articulation to a point midway between the angle of the jaw and the mastoid process. Each artery lies against the anterior spinal muscles, the longus colli, and rectus capitis anticus major. Each is contained in a dense cellular sheath, which includes, besides the artery, the internal jugular vein on its outer side, and the pneumogastric nerve between the artery and vein. In front of the sheath, and connected to it, lies the descendens noni nerve, which sweeps downwards, and about the middle of the neck unites with a branch of the cervical plexus, to form a loop from which branches are given off to the muscles that pull down the larynx. Behind the sheath lie the sympathetic and cardiac nerves, and at the lower part the inferior thyroid artery and recurrent nerve cross behind it towards the larynx. Yet it must be recollected that occasionally the descendens noni has been found within the sheath, or behind the artery; and that the inferior thyroid artery has been found in front of the carotid. On the inner side lie the pharynx and œsophagus, trachea and larynx, and the thyroid gland, which last somewhat overlaps the artery. On the outer side are chains of lymphatic glands.

The left artery and the right differ in their origin, and in their relations during the first part of their course. The left arises from the arch of the aorta, and rests at first on the side of the trachea, thoracic duct, and œsophagus, and behind the border of the manubrium and sterno-clavicular joint. Both terminate opposite the upper border of the thyroid cartilage by dividing into internal and external carotids. The left jugular vein lies rather in front of the left carotid, as it goes to empty itself into the left brachio-cephalic vein, which crosses the artery at its origin.

The right carotid arises from the arteria innominata, and ascends rather more perpendicularly. The right internal jugular vein is more external than the left, and near its termination diverges somewhat from the artery. This makes a little difference in tying these arteries low down.

Each artery is covered by the sterno-mastoid, sterno-hyoid, and

* Full information on the subject of this chapter will be found in Mr. Heath's work on Minor Surgery, Bandaging, &c. Lond. 1861.

sterno-thyroid muscles, and is crossed by the omo-hyoid, generally about two inches above the clavicle. A dense fascia is connected with

this muscle. In the upper part of its course, corresponding to the larynx, the sterno-mastoid leaves the carotid, which is then covered only with skin, platysma, and fascia. Both common carotids terminate opposite the upper border of the thyroid cartilage, by dividing into internal and external carotids.

The carotid artery, in the lower part of its course, may require to be tied for aneurysm in the upper part of the trunk. In the upper part, the operation may be necessary for hæmorrhage or for erectile or other tumours about the face or orbit; moreover, it may be expedient, on Brasdor's principle, in aneurysm too low down to admit of a ligature between the disease and the heart.

To tie the Carotid in its lower part.—The patient being placed on his back, with the shoulders raised, and with the head thrown back and slightly turned towards the opposite side, an incision three inches in length is made on the inner margin of the sterno-mastoid muscle. This incision should be carried through skin, platysma, and superficial fascia, and should extend from opposite the lower part of the thyroid cartilage, to a quarter of an inch above the sternum. The head should now be turned to the side operated on, and be brought a little forwards, so as to relax the sterno-mastoid muscle, the edge of which is to be

exposed, and a vein that usually runs in this direction to be looked for and avoided. With slight use of the finger or handle of the scalpel, the

sterno-mastoid must be separated and drawn outwards, and the sterno-hyoid and thyroid muscles inwards. If it will at all make matters more easy, the lower and inner portion of the sterno-mastoid may be divided, and the same may be said of the omo-hyoid, which should now be sought for near the upper part of the incision. The dense fascia which unites this muscle to the sheath must now be scratched through, and the sheath will be seen, with the descendens noni upon it, which should be drawn to the inner side. The greatest care should be taken throughout, and more particularly now, to avoid the numerous thyroid and other veins to be met with. The sheath must be pinched up with forceps, and opened with a cautious touch of the knife, whose flat surface should be held towards the artery. The aperture is to be enlarged on a director, and an aneurysm needle,—a curved blunt needle with *the eye near the point*,—armed with a ligature, to be passed

round the vessel from without inwards, the point of the needle being kept close to the vessel in order to avoid the vagus nerve. When its point appears on the inner side, the surgeon seizes the ligature with forceps, and withdraws the needle; ascertains that the nervus vagus is not included in the ligature, and then ties tightly a double knot as represented at page 35. One end of the ligature may then be cut off close to the knot, and the other be left hanging out of the wound, which is to be closed with plaster when bleeding has ceased. The patient must be kept at perfect rest in bed till the ligature separates.

As a rule, on the right side the ligature should be applied as high as possible: on this side too there may be no trouble with the internal jugular. On the left side, this vein will, in all probability, get in the way and require to be drawn outwards. On this side too the relation of the œsophagus internally, and of the thoracic duct posteriorly and externally must be remembered, as these parts must be avoided carefully.

To tie the Common Carotid in its upper part.—The patient is placed in the same position as before, but with the head more thrown back. An incision of three inches is made through skin and platysma, on the anterior edge of the sterno-mastoid muscle, from a little below the corner of the lower jaw to opposite the cricoid cartilage. The deep fascia, here very dense, is to be pinched up, opened, and further divided on a director most carefully, in consequence of its intimate connection with the sheath of the artery and with the veins. The edges of the wound are now to be drawn asunder, the pulsation of the artery sought for, and the sheath opened over it, in the manner and with the precautions before described; a small portion only of the vessel must be exposed, and the ligature passed as before directed. The jugular vein will be more difficult to avoid here than in the lower part of the neck.

II. The External Carotid may, if wounded, require a ligature; or if any of its branches are wounded, *and cannot be tied*; but such an operation is very rarely, if ever, practised, ligature of the common carotid being preferable. An incision of the same length and direction as in the two preceding operations should be made through the skin, platysma, and sheath, so as to tie the vessel near its origin, below the part where it is crossed by the digastric muscle and ninth nerve.

To tie the external carotid above the digastric muscle, before it has gained the parotid gland, the head should be well extended, and an incision made from the lobe of the ear to the great cornu of the os-hyoides, successively through the skin, platysma, and superficial fascia. The student must not expect to meet with the deeper parts in this situation disposed, as they appear in the dissecting-room, after they have been dissected, when in fact they are completely displaced and pulled down. The parotid gland first comes into view, by raising the border of which, the anterior edge of the sterno-mastoid is exposed, and also the posterior bellies of the digastric and stylo-hyoid muscles. Along the upper edges of the latter the vessel may be found entering the parotid. Con-

siderable venous hæmorrhage will be encountered in this operation, which is very difficult to execute well, even on the dead body.

III. THE INTERNAL CAROTID is sometimes wounded by gashes, stabs, or shot from without, or by punctures from within, as may happen when a person falls down with a tobacco-pipe in his mouth, and drives it through the back of the pharynx. In such cases, ligature of the common carotid is a very uncertain remedy, and Mr. Guthrie proposes (in compliance with the rule of always securing a wounded artery by two ligatures, one above and one below the wounded part) to reach the wounded vessel by operation. The leading feature of this operation is, the removal of the second molar tooth, and division of the lower jaw-bone, so that the angle of that bone may be everted, and room be given for reaching the vessel. Mr. Mayo once tied this artery, and in order to reach it cut through the styloid process of the temporal bone.*

IV. THE LINGUAL ARTERY may be tied by making a transverse incision along the os hyoides, from a little below the symphysis of the jaw to near the border of the sterno-mastoid muscle. The skin, platysma, and fascia being divided, and the lower border of the submaxillary gland turned up, the artery must be looked for where it lies upon the greater cornu of the os hyoides, below the digastric muscle and ninth nerve. This artery has been tied in cases of tumours and wounds of the tongue; but, considering the depth at which it lies from the surface, the irregularity of its origin, and the important parts in its vicinity, it is much better, as a general rule, to tie the external or common carotid.

V. THE FACIAL ARTERY may easily be tied by cutting through the skin and areolar tissue that cover it where it turns over the jaw, at the anterior border of the masseter; but such an operation can hardly ever be requisite.

SECTION II.—THE INNOMINATA, SUBCLAVIANS, AND ARTERIES OF THE ARM.

I. THE ARTERIA INNOMINATA has been tied in cases of aneurysm of the right subclavian, extending inwards as far as the scalenus. The patient being placed on his back, with the shoulders raised and the head thrown back, one incision, two inches in length, is to be made along the inner margin of the sterno-mastoid muscle, terminating at the clavicle, and another across the origin of that muscle, meeting the former at a right angle. The flap of integument thus formed is to be turned up, and the sternal and part of the clavicular origin of the sterno-mastoid are to be divided on a director, which is to be passed behind the muscle, and kept as close to it as possible. The areolar tissue and fat which now appear, being turned aside, the sterno-hyoid, and sterno-thyroid muscles must be separately divided on a director. A

* For further particulars of Mr. Guthrie's operation see Lancet, 1850, vol. ii., p. 143.

strong fascia, which next appears, must be cautiously scratched through, and the carotid be traced with the finger, down to its origin. Then the vena innominata being depressed, a ligature may be carried from without inwards, round the artery, close to its bifurcation, taking care to avoid the vagus, recurrent, and cardiac nerves.*

In *Aneurysm of the Innominata* it is impossible, or if possible fatal, to place a ligature between the tumour and the heart; and the ligature of the carotid or subclavian, or both, seemed the only resource, till Mr. Edwards, of Edinburgh, attempted to give relief by pressure. An unhealthy woman of 50 had a tumour the size of an apple situated between the sterno-mastoid muscle and the middle of the neck, pulsating violently, soft and compressible, feeling like a vulcanized india-rubber ball, which, though compressible, expands the moment pressure is withdrawn. Another pulsating tumour rose in front of the trachea: they were the evidently distinct bulgings of one aneurysm, as pressure on one increased the size of the other. These tumours were of two months' growth, increasing rapidly, and attended with great dyspnœa.

Brasdor's operation was contemplated, but abandoned because aneurysm of the aorta was suspected. Then Mr. Edwards determined to apply pressure to the carotid and subclavian arteries. This was accomplished by two conical pads of cork; one attached to an arc of steel in which the neck rested, and which was supported by an upright rod, attached to a very firm broad girth round the chest; the other to a band over the shoulder. The instrument was so adjusted as to stop all pulsation in the branches of the external carotid, and of the wrist of the affected side. Every morning for the first two weeks, Mr. Edwards roughly manipulated the sac for the purpose of breaking up the fibrine. For the first two days, the tumour seemed to become thinner, and the pulsation more violent; after that it became more solid; and in three months the aneurysm of the innominata was virtually cured, whilst that in the aorta had made little progress.†

Dr. William Wright, of Montreal, has published an interesting account of a case in which he prolonged a patient's life for a month, by ligature of the right carotid, when death was imminent from a bursting

* This operation was first performed by Mott, at the New York Hospital, in 1818. The patient walked out on the 20th day, bleeding from the wound occurred on the 21st, and he died on the 26th. The arch of the aorta was extensively diseased. Dr. Graefe performed it in 1822 at Berlin; the patient died of hæmorrhage on the 67th day. See Cooper's Surgical Dictionary, Art. Aneurism; South's Chelius, vol. ii., contains details of half a dozen cases. The operation was successfully performed by Dr. A. W. Smith, of New Orleans, in May and June, 1864. The innominata and right carotid were tied on May 13, and the *vertebral artery* on the 9th July. This last operation cut off the supply of blood from the sac; bleeding from the wound ceased, and the patient was well on the 19th. Med. Times and Gaz., Sept. 24, 1864, from American Medical Times.

† Case of Mrs. Denmark, by Wardrop (ligature of subclavian), quoted in Cooper's Surg. Dict.; case by Mr. Evans, of Belper, in which the carotid was tied, ibid.; case in which Mr. William Wickham, of Winchester, tied the carotid and then the subclavian, Med. Chir. Trans., vol. xxiii.

aneurysm of the innominata;—and shows that his operation is superior to the ligature of the subclavian in the third part of its course, inasmuch as half the current of blood through the aneurysm is obstructed; whereas by tying the subclavian only one-sixth is obstructed, because its chief branches are given off on the near side of the ligature.*

II. THE RIGHT SUBCLAVIAN ARTERY, in the first part of its course, that is to say, between its origin from the innominata and the scalenus muscle, has been tied for aneurysm in the second and third parts of its course, by an operation almost precisely similar to the foregoing; but it is the most difficult operation in surgery, and the most unsuccessful.

III. THE SUBCLAVIAN ARTERY, in the third part of its course, is about an inch and a quarter long, and passes from the scaleni muscles downwards and outwards under the clavicle to the lower border of the first rib, where it takes the name of axillary. Its depth will depend on the greater or less curve of the clavicle, the length of the neck, and the width and position of the shoulder, whether high or sloping. Above is the omi-hyoid muscle (posterior belly). Behind is the scalenus medius, with the first dorsal nerve intervening, and below the upper surface of the rib. In front are the skin, platysma, supraclavicular nerves and vessels, cervical fascia, and areolar tissue of varied density. The clavicle and the subclavius muscle are also before it. The subclavian vein is on a plane anterior, but inferior and internal, and nearly concealed by the clavicle. It is here joined by the external jugular, by the posterior scapular, and by other small veins from the shoulder and the side of the neck, which sometimes form a large and intricate plexus. The brachial nerves are above and behind.

Some of the irregularities in the subclavian artery are of practical interest. The artery may perforate the anterior scalenus, or lie in front of it, close to the subclavian vein. The vein has been met with accompanying the artery in its usual course between the scaleni. On the right side the artery may come from the back part of the innominata. Very frequently (in half the number of cases) the third part of

* Cases of aneurysm near the aortic arch, in which pressure cannot be used, nor the vessel tied, are those in which (if any) it may be expedient to try Mr. Moore's plan of filling the sac with iron wire. It is necessary that there be no strong current *through* the sac. His instruments are "a straight short canula of thin silver, sharply pointed at one end, expanded at the other, and with its tube somewhat larger than is sufficient to give ready passage to the wire;" and a thicker wire, large enough to fill the canula, to serve as a probe. The aneurysm is punctured in its side; the sac explored with a probe; then yard after yard of fine iron wire, just stiff enough to pass the canula without bending, is pushed in (26 yards were pushed in during one hour in Mr. Moore and Dr. Murchison's case); whilst being pushed in the canula must be gently moved, so that it may be distributed fairly through every part of the sac; when the sac is filled, the wire is cut off, and the end of it pushed right through the canula into the sac, that it may not remain in the wound, which, lastly, is closed by collodion. The first effect in the case quoted was cessation of pulsation in the sac; but after twenty-four hours rigors came on, and the patient died after four other days of great agony. See *supra*, p. 345, for the distinction between *active* and *passive* clot in aneurysms. Mr. Moore and Dr. Murchison's case, Med. Chir. Trans., vol. xlvii.

the subclavian artery gives origin to a branch of considerable size, which becomes the posterior scapular. When this arrangement is present, the main trunk must be secured on the cardiac side of the branch, or if that endangers the pleura by its contiguity the branch also must be tied.

Both subclavians may rise higher in the neck, an inch or more above the usual position, which is just a little above the clavicle; and the right is the more subject to this variation.

The vessel may readily be felt in the lower division of the posterior triangular space of the neck, immediately behind the clavicle; and here it may be compressed by the fingers.

The patient should be laid on a table, with the shoulder of the affected side drawn downwards and forwards as far as possible, and the head turned to the other side. An incision must then be made above and parallel with the clavicle, three or four inches in length. It should cut through the skin and platysma, and should extend from over the outer edge of the sterno-mastoid to the trapezius. The preliminary incision may be conveniently made by drawing down the skin, and cutting through it while it is steadied on the clavicle.

The external jugular vein will probably now be seen, and should be drawn with a blunt hook, to whichever side is the more convenient, and if need be, tied with a double ligature, and cut. The clavicular portion of the mastoid muscle, if unusually broad, should be severed. Perhaps it will be best to do so in all cases. The knife must now be used very sparingly to divide the fascia, and if it can be dispensed with altogether, so much the better, and the dissection continued by tearing, scratching, and picking with directors and probes, some of which should have points like knitting-needles. The omo-hyoid muscle must be sought for and drawn up. Here, in a space bounded above and externally by this muscle, internally by the sterno-mastoid, and below by the clavicle, are the artery and the brachial plexus of nerves. The omo-hyoid varies in its position; sometimes it runs close to and parallel with the clavicle, and then without great caution the dissection might be made above the muscle. It may have a partial attachment to the clavicle, or get its entire origin from this bone; or may be very high, or altogether absent. The supra-scapular, and even the transversalis colli arteries may be met with, and must be drawn aside.

The great landmark, the anterior scalenus muscle, must be searched for with the forefinger, and be traced to its insertion in the rib, which is marked by a bony tubercle usually evident to the finger. The precise position of the artery will then be ascertained, and the fascia and areolar tissue that cover it should be carefully torn through. It it is now that the use of dividing a portion of the sterno-mastoid is apparent. Some of the lower branches of the brachial plexus of nerves always appear first, and are very likely to be taken up instead of the vessel; but the peculiar aspect of the artery should be well looked for in order to avoid this mistake. Indeed the appearance of the artery and the cessation of the wrist pulse when it is pressed upon by the

finger should alone be trusted to; for sometimes when its coats are thickened, pulsation is not evident in the trunk itself.

Venous hæmorrhage is often most troublesome, and when pressure on the smaller veins does not readily stop it they must be tied. If the subclavian vein is wounded, pressure alone can be employed. The act of passing the needle under the artery has been attended with almost incredible difficulties, and so has the tying of the ligature, and many ingenious instruments have been devised to render both of these proceedings more easy.

IV. THE AXILLARY ARTERY is that portion of the main trunk of the arm, which extends from the lower border of the first rib, to the lower edge of the tendons of the latissimus dorsi and teres major in the axilla. Its entire course is that of a gentle curve, with the convexity outwards and upwards. For surgical purposes it may be divided into two portions, the former being the upper part of its course, where it lies thickly covered by muscle, and the latter being the lower part, where it can be felt against the humerus in the axilla.

In the upper part of its course the artery lies upon the first intercostal space, and on the second digitation of the serratus magnus; its vein lies internal, the brachial plexus is above and behind it; afterwards it encircles the artery. It is in the case of wounds that an operation is likely to be attempted in this situation: or in the case of aneurysm, when the subclavian cannot be tied above the clavicle. See *Symes' Operation*, p. 349.

In such cases, the dissection must be carried down to the artery, through any muscle that may be in the way, and according to the circumstances of the case. But the following operation may be practised in the dissecting-room.

To tie the Axillary Artery in the upper part of its course.—The shoulder should be thrown back, and the arm drawn back, so as to put the pectoral muscle on the stretch. An assistant should be at hand to compress the subclavian artery if necessary. An incision four inches long should be made from the coracoid process inwards in a transverse depending curve half an inch below the clavicle, to the edge of the deltoid muscle; recollecting that the cephalic vein and thoracico-acromialis artery, which run in the interval between the pectoral and deltoid muscles, should not be injured. The pectoralis major should then be divided to the same extent. Now there may be a pause to check hæmorrhage, which being accomplished, and the lower border of the wound being well drawn downwards, the areolar tissue is to be carefully cut through, and then the edge of the pectoralis minor will come into view, going upwards and outwards over the vessels and nerves to be inserted into the coracoid process. Any branches of the thoracic arteries that may be wounded should at once be tied. The next point is, to scratch through the *costo-coracoid*, or *coraco-clavicular* fascia: a dense fascia extending from the first rib to the coracoid process, and from the upper edge of the pectoralis minor muscle, to the subclavius. At this stage of the proceedings, the arm should be brought

to the side, to relax the pectoralis major. And now some touches with a blunt director will probably expose the axillary vein, which should be pressed inwards and there kept with a blunt hook. The beating of the artery must now be sought for, the vessel isolated, and an aneurysm needle be passed from without inwards, with all care not to include any of the nerves (which lie on the outside and behind), either along with the artery, or instead of it.

It would be possible to tie the artery below the point where it is crossed by the pectoralis minor, by extending the incision downwards.

To tie the Axillary Artery in the axilla.—The patient being placed on his back, the arm must be as widely as possible separated from the trunk, and the fore-arm supinated, and the whole limb rotated in the same direction. The surgeon will then make out the anterior and posterior boundaries of the axilla, the anterior constituted by the pectoralis major, the posterior by the latissimus dorsi and teres major, which go to their respective insertions at the edges of the bicipital groove. Between these muscles the axillary vessels and nerves lie, and can be felt against the upper extremity of the humerus; with the upper part of the coraco-brachialis between the vessels and the pectoralis major. The surgeon will recollect the relation of the nerves of the axillary plexus to the artery at this point. The external cutaneous nerve (which perforates the coraco-brachialis muscle) with the outer root of the median lie to the outer side; the inner root of the median, the ulnar and internal cutaneous, on the inner side, and the circumflex and musculo-spiral behind.

The operator makes an incision two or two and a half inches long, over and parallel with the upper extremity of the humerus, between the pectoralis major and latissimus dorsi, but rather nearer the latter. It should cut through the skin. Then a cautious dissection through fascia will reveal the axillary vein and median nerve,* the former of which should be drawn inwards, and the latter outwards, whilst the artery is cleared by careful scratches with probes of various degrees of bluntness, else the thoracic and subscapular veins may be wounded. The aneurysm needle is passed between the vein and artery.

There are frequent *irregularities* in the relation of this artery to the nerves and veins, the knowledge of which should make the surgeon careful. Instead of one vein, there may be two or three. There may also be irregularities in the course and distribution of the branches of the artery, the most important of which practically is a high separation of the radial or ulna in the axillary space. There may be a double brachial; and the superior profunda may have a common origin with the posterior circumflex, or even with the subscapular, and form a branch large enough to be mistaken for the brachial or axillary. When this is the case, it may be necessary to secure both, if it does not accomplish the end proposed.

* In case of difficulty, find the inner border of the coraco-brachialis, between which and the artery lies the median nerve. Malgaigne, Operative Surgery, by Brittan, p. 130.

V. THE BRACHIAL ARTERY runs obliquely down the inner side of the humerus, to the middle of the bend of the elbow; it runs along the inner border of the coraco-brachialis and biceps respectively, which muscles successively overlap it a little, and form the best guides to it. Its pulsations may be felt along the whole of its course, and it is covered only by skin and fascia, though from the thickness of these the operator may not find it so superficial as he may imagine it to be. It is accompanied by two venæ comites, whose numerous branches encircle it; and by the median nerve, which first lies on its outer side, between it and the coraco-brachialis, then crosses over it, so as to be quite internal to it at the elbow, where both become covered by the semilunar fascia of the biceps.

There are several irregularities not very unusual, which the surgeon should be prepared for. The median nerve may run parallel with the artery, over it, under it, or on the outer side. The internal cutaneous nerve, instead of being superficial, may be deep; and the basilic vein which lies beneath the skin, over and parallel with the artery, in its lower third, may ascend superficially up the arm. The radial artery may arise from the upper third of the brachial, or even from the axillary. The ulnar may also have a high origin, and run either superficially or deeply to the wrist. The same may happen to the interosseous artery.

To tie the brachial in its upper third.—The limb is to be drawn from the side and supinated. The surgeon makes out the coraco-brachialis muscle, endeavours to ascertain the course of the basilic vein, and to feel the pulsation of the artery. Then he makes, carefully, an incision three inches in length over the artery, recollecting that the skin

is here very thin, and taking care not to cut the internal cutaneous nerve. The fascia should next be divided to the same extent; and under it probably the basilic vein will be found, to the inner side of the artery. Now the fore-arm may be bent to relax the parts, and the coraco-brachialis be drawn outwards. Any veins or nerves in the way may be drawn aside with a blunt hook; the sheath of the artery be opened, and the median nerve which comes into sight be drawn out-

wards. Now the operator must carefully identify the artery by its pulsation, or by the appearance of its coats; but it may not pulsate unless the muscles of the limb are relaxed. The needle must be passed in whatever direction the operator finds most convenient for avoiding the veins.

Should a large branch be exposed, the trunk must be tied above and not below it. Should two large arteries be found running parallel, it must be ascertained by pressure which of them communicates with the aneurysmal sac, or the wound, and that one tied; but if no effect be produced, except both be compressed, then both must be secured. Should it happen when only one vessel is apparent, that compression on it does not check bleeding or pulsation below, search must be made for a second one. When the ligature is applied very high, the proximity of the origin of the superior profunda artery must not be forgotten.

To tie the Brachial Artery in the middle of the arm, the incision should be along the inner side of the biceps. The basilic vein will probably be found passing from its superficial to its deeper course. The median nerve will, if regular, be seen lying over the vessel, and should be drawn either outwards or inwards, and the biceps be well relaxed. The operator should be on his guard not to mistake the inferior profunda artery and the ulnar nerve, for the brachial and the median nerve, an error liable to be made if the profunda has become enlarged, and best avoided by dissecting towards the biceps, or rather towards the centre of the limb, and not getting too far internally. The middle third of the artery should be tied, when such an operation is required for hæmorrhage from the hand, or from the interosseous vessels.

To tie the Brachial Artery in its lower third. — This operation has been most frequently done for aneurysm, produced by careless venesection, and there can be no doubt that in the large majority of small

circumscribed aneurysms, it will be sufficient to tie the artery just above the tumour, and as near it as possible.

In the case of traumatic aneurysm, the difficulties of the surgeon will be increased by the infiltrated and swollen state of surrounding parts, and possibly the tumour may be the only guide to the vessel. An incision from two and a half inches long to three inches, should be made obliquely about half an inch internal to the tendon of the biceps, the position of which should of course be first ascertained. The basilic vein must be held aside if in the way, as well as any twigs of nerves. The fascial expansion of the biceps must not be needlessly cut, as contraction of the arm might ensue, or the healing of the wound become tedious.

Should it be considered necessary to tie the brachial very low down in consequence of the radial having been wounded, the vessel lies in a triangular space, bounded by the pronator radii teres internally, and by the supinator longus externally, having the median nerve, when regularly placed, on the inner side. Very great care should be taken to conduct the operation with delicacy and despatch.

It may be observed that when the artery is wounded in venesection, the surgeon has the choice of three measures:—1st. To enlarge the wound upwards and downwards, and tie the vessel above and below the injured part. 2ndly. To attempt cure by pressure; placing a graduated compress on the wound: bandaging the whole limb: compressing the artery above, and so endeavouring to get the wound in the vessel closed, without traumatic aneurysm resulting. Should this aneurysm result, and be *diffused*, that is, without a sac, the wounded artery must be secured. Should the traumatic aneurysm have a sac, either this tumour may be cut into and both ends of the vessel tied, which is usually the most advisable proceeding; or recourse may be had to, 3rdly, ligature of the lower part of the brachial.

VI. THE RADIAL ARTERY pursues a course corresponding with a line drawn from the middle of the bend of the elbow to the base of the metacarpal bone of the thumb. It winds over the external lateral ligament of the wrist joint to the dorsum, and between the first and second metacarpal bones sinks into the palm of the hand to complete the deep palmar arch. Although in the upper part of its course it lies deeply and is overlapped by muscle, it is not crossed by any. In the upper third it lies deeply between the pronator teres and supinator longus, and is overlapped by the latter. In the lower two-thirds it lies between the tendons of the supinator longus and flexor carpi radialis. It is accompanied and embraced by venæ comites and their ramifications, and in the middle third by the radial nerve, which lies on the outer side and behind. It sometimes happens, as an irregularity, that the artery runs superficial to the supinator longus, or even to the fascia; and at the wrist may pass outside the extensor tendons.

To tie it, the fore-arm must first of all be properly fixed by assistants on a table. Then an incision three inches in length must be made over its course. The superficial fascia should be divided; the deep fascia

must be slit up, the supinator longus turned aside; and if the vessel is tied in the upper third, care must be taken to cut *between* the muscles without wounding them.

To tie the Radial Artery on the outer side of the Wrist, an incision should be made through the skin, from opposite the styloid process of the radius, to the commencement of the first interosseous space. The tendon of the extensor secundi internodii pollicis, which crosses the artery just before it dips into the palm, is the best guide to it; and it will be easier to tie the vessel on the ulnar side of the tendon.

VII. THE ULNAR ARTERY, larger than the radial, passes from the middle of the bend of the elbow obliquely inwards, forming a slight curve with the concavity outwards, and then nearly vertically along the ulnar side of the fore-arm to the wrist; where it passes over the

annular ligament on the radial side of the pisiform bone and enters the palm. In the upper half of the arm it is covered by the four superficial muscles which arise from the internal condyle. In the lower half it is nearly superficial, and lies between the flexor digitorum sublimis, and the flexor carpi ulnaris, the latter of which is on the ulnar

side. Except in very thin persons, the tendon of the flexor carpi ulnaris overlaps the artery, within two or three inches of the wrist, and so does the inner tendon with more or less of the muscular fibres of the flexor digitorum sublimis; so that, in fact, the vessel is not quite superficial.

Like the radial it is accompanied by two veins. The median nerve lies first to the inner side separated by the ulnar origin of the pronator radii teres: it then crosses in front of the artery and descends along the middle of the limb. The ulnar nerve becomes attached to the artery at about the lower part of the upper third of the fore-arm, lying to the ulnar side. On the annular ligament, it lies next to the pisiform bone, and rather posterior to the artery. When there is a high division of the ulnar, the vessel almost always passes superficial to the muscles, generally under the fascia, sometimes above it.

To tie the Ulnar Artery in the upper third of its course, a longitudinal incision, as shown in the woodcut, a quarter of the width of the arm from the inner edge, which will of course cross the artery, will be preferable to one more in the direction of the vessel; as the edges of the wound can be better separated, and what is of more consequence, the natural division that exists between the flexor carpi ulnaris and the next muscle, can be easily found. Should it be requisite to cut between the muscular mass more externally, the division should be made very low, and, if possible, between the tendons of the muscles, and carried upwards. The ulnar nerve should be looked for, as when seen it may serve as a guide to the artery.

To tie the Ulnar Artery just above the wrist, requires rather more care than to tie the radial. An incision, two inches long, should be made, and it should be about three-quarters of an inch from the inner edge of the limb. The operator should endeavour to feel the tendon of the flexor carpi ulnaris muscle, and when he can, to cut just external to it. If he cuts too internally, the muscular fibres of the lower part of this muscle will bulge, and perhaps perplex him. After the skin and fascia have been divided, the artery must be sought for, covered by the tendon of the flexor carpi ulnaris, which is internal, and the inner tendon of the flexor digitorum sublimis, and the fibres of that muscle, which is external. The venæ comites are to be separated. As the ulnar nerve lies to the inner side of the artery, the needle had better be passed from within outwards.

VIII. THE SUPERFICIALIS VOLÆ, the artery which continues in the course of the radial, and goes to join the superficial palmar arch, is usually small, but yet a frequent source of troublesome hæmorrhage when the ball of the thumb is wounded. But it may be a very large artery and bleed profusely, and then must be tied at the seat of injury.

Hæmorrhage in the palm of the hand may, when practicable, be stopped by tying both ends of the bleeding vessel; yet it is seldom that this can be done, on account of the manner in which the vessels retract, and of the density of the surrounding parts. The propriety of enlarging the wound, with the object of effecting this, must depend on the circum-

stances of the case, and can rarely be admissible about the centre of the palm. Yet if the blood spirts out with a jet, the exploration may be justifiable, as it would thus be shown that the bleeding orifice was near. Otherwise (following the practice of Mr. Pollock at St. George's) pressure should be made by a horse-shoe tourniquet on the brachial artery as for aneurysm, and the wound be left bare to the air. Or, see page 335.

SECTION III.—THE AORTA, ILIACS, AND THEIR BRANCHES.

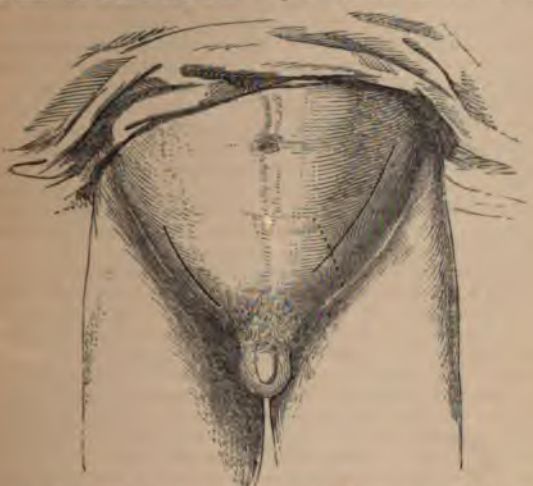
I. THE EXTERNAL ILIAC ARTERY is not unfrequently tied for aneurysm, high up in the femoral. The process for tying it, as well as the internal or common iliac, is to cut through the abdominal muscles and fascia transversalis, and to get behind the peritonæum without wounding it, so as to reach the point desired. Before any of these operations, the bowels should be well cleared.

The bifurcation of the aorta corresponds as nearly as possible with a spot a finger's breadth below and to the left of the navel. From this point, a line drawn to the middle of Poupart's ligament, will coincide with the course of the iliac; the upper third to the common, the lower two-thirds to the external iliac.

The *common iliac* extends from the bifurcation of the aorta, on or about the body of the fourth lumbar vertebra, to the sacro-iliac synchondrosis. Its length may vary extremely in different subjects: it is usually two inches; but if the aorta bifurcates higher up than usual, or if the common iliac bifurcates lower than usual, its length may be increased to 3·5 inches. Under the opposite conditions, it may be only .75 inch. Each common iliac is covered by peritonæum, and crossed near its bifurcation by the ureter; each, too, is in close relation with its vein; but in this respect there is a difference, for both left and right common iliac veins pass behind the right iliac artery to reach the cava, and the artery is closely connected to them both. Whereas the left common iliac artery has a slight space between it and its vein, which lies below and internal to it. The superior hæmorrhoidal artery also crosses the left common iliac artery.

The *external iliac artery* runs in the course we have described, along the inner border of the psoas muscle, having its vein on the inner side and below. The genito-crural nerve, which pierces the psoas, lies on it for a short distance, and there is a chain of lymphatic glands surrounding both artery and vein, which, if enlarged, may give great trouble. This artery is invested by the peritonæum, and crossed high up by the rectum on the left side, and by the ileum on the right, and occasionally by the ureter. Low down, near Poupart's ligament, it is crossed by the spermatic cord in the male, and the round ligament in the female. In both, it is here crossed by the circumflex iliac vein, and gives off the deep epigastric and circumflex iliac branches. Occasionally, the obturator branch arises from the epigastric or external iliac, and crosses down to the inner side of the latter to the thyroid hole.

To tie the External Iliac, the patient should lie flat on a table, in order that the abdominal muscles may be rendered rather tense. An



incision, three and a half or four inches long, should be made above and parallel to Poupart's ligament, beginning about half an inch outside the external abdominal ring. It should be carried through skin and the superficial fascia, and be completed so as to lay bare the external oblique tendon. If the external epigastric artery be divided, as is probable, it should be secured. The tendon of the external oblique should next be cut through to the same extent, either on a director, or not. The internal oblique and transversalis muscles are now to be similarly divided; and as they vary in thickness, and as the peritonæum is close behind, this part of the operation must be conducted with great delicacy. A portion of the muscle should be lifted with forceps, and be carefully cut through, to form an opening into which the finger, or a large blunt director may be insinuated, and upon which the muscle may be divided. The edges of the wound should now be gently drawn asunder by bent spatulæ; the fascia transversalis be exposed and scratched through, and the opening be enlarged by tearing with the fingers. And next the peritonæum should be most delicately stripped off, from the walls of the abdomen and from the iliac fossa, till the finger reaches the artery, as it gradually rises from the pelvis. The sheath must be scratched through with the finger-nail or a director at the point selected, and the artery separated from the vein; the aneurysm-needle should be passed between them, and the genito-crural

nerve be excluded from the knot. The wound should be brought together by sutures, the trunk be bent forwards to relax the muscles, and pressure be applied by means of a bandage and pads of cotton wool.

Sir Astley Cooper, of whose method of operating the above is a modification, separated the internal oblique and transversalis muscles from Poupart's ligament, instead of cutting through them rather higher up, as described above. The advantages of the latter plan are, that the epigastric and circumflexa ilii arteries, and the circumflexa ilii vein which crosses the artery low down, are not interfered with, neither is the spermatic cord, nor the abdominal ring. Moreover, if it should seem expedient to tie the vessel higher up, it might be done without much difficulty, by drawing up the upper edge of the wound. The circumflexa ilii and epigastric arteries are of importance for the collateral circulation. But, on the other hand, it must be confessed that the peritonæum is rather more interfered with.

In the method of operating recommended by Abernethy, the incision is made in the course of the artery, instead of across it, as in Sir A. Cooper's method. It extends upwards and inwards about three inches, from an inch above the centre of Poupart's ligament, towards the umbilicus; being longer in proportion to the stoutness of the patient. The subsequent steps are those of Sir A. Cooper's plan. This operation is convenient for cases in which it is doubtful beforehand whether the external or the common iliac should be tied. Its disadvantages are, that the peritonæum is very much disturbed, and that there is greater liability to hernia afterwards.*

II. THE COMMON ILIAC ARTERY.—In order to tie this artery, an operation has been proposed similar to that of Cooper for the external iliac; but it would be very difficult in a thin patient, and almost impossible in a fat one. It is better to make the formidable curved incision shown in the cut (p. 757).

An incision is made from six to eight inches in length, the lower third being about an inch and a half or two inches above Poupart's ligament, and parallel with it. The muscles must be divided, and the transversalis fascia torn through, according to the rules given for exposing the external iliac artery. In fact, there is no practical surgical difference between them, except that the operation under consideration is more difficult, and requires more care and more assistants. The intestines are sure to bulge more or less into the wound directly that the fascia transversalis is divided, and here is the chief difficulty to be encountered. With the greatest gentleness they must be drawn upwards, while the operator separates the peritonæum from the iliac fossa. There need be no apprehension about the fate of the ureter, as

* This artery was tied by Mr. Partridge, in the King's College Hospital, in November, 1846, for aneurysm of the common femoral, in a patient only 23 years old. It was tied by Mr. Thomas Nunn, in January, 1849, for aneurysm of the common femoral, and by Mr. H. Smith, in August, 1850, for aneurysm of the superficial femoral high up. The ligature came away on the twenty-eighth day. All three patients did well. Mr. Smith has at different times tied the external iliac on one side, and the superficial femoral on the other, in the same patient.

it is always raised along with the peritonæum, the two being closely united. Having gained the soft brim of the pelvis, the operator may seek the external iliac, and if not very much diseased, it will be readily found, and form a good guide to the common trunk. The sheath of the vessel must be opened just above the bifurcation, and the needle be passed, if possible, from within to without.*

Another, or *posterior* operation, was proposed by Sir P. Crampton.† It has not yet been successful, but is certainly not without apparent merits. By it the peritonæum is very much less disturbed, and the vessel is fully exposed. The walls of the abdomen, too, are opened at a part where it is less likely that hernia will ensue. But further trial must determine its merit. The following is the manner in which it was performed by Mr. Stanley at St. Bartholomew's Hospital in 1846, as detailed by Mr. Skey.

The patient, a middle-aged man, was placed on the operating-table, with his body inclined over to the right or sound side. The shoulders and trunk were bent a little forwards, for the purpose of rendering the lumbar integument tense. The line of the last false rib having been ascertained, an incision of three or four inches in length was made from its cartilage or nearly its point, in a line downwards, and somewhat forwards, to the crista ilii. The skin and fascia, then the external oblique, internal oblique, and transversalis muscles were singly and successively divided. The external incision was then carried along the line of the crista ilii, to the extent of about three inches more, and the division of the three muscles from the bone completed. There was but little blood lost. Returning to the situation of the first incision, Mr. Stanley then divided the transversalis fascia to the entire limit of the external wound. He then raised the mass of intestine enveloped in the peritonæum, and pushed it inwards, bringing into view the psoas magnus, left ureter, and finally the common iliac artery, around which he passed a ligature, without apparent difficulty.

III. The Internal Iliac Artery.—Of the seven cases in which this artery has been tied for disease of its branches four have recovered.

The operation is necessarily attended with the greatest difficulty, on account of the position of surrounding parts. The internal iliac vein is closely in contact with the artery, each vein being a little posterior to the corresponding artery and to its right side, while each artery crosses the course of the external iliac vein. Then the internal iliac veins have their coats very thin, they lie loosely about the artery, and

* The common iliac artery was tied by Mr. A. M. Edwards, of Edinburgh, in a case in which an aneurysm of the external iliac artery had burst internally, and the patient was bleeding to death. Mr. Edwards made the incisions described in the text, and with great difficulty reached the common iliac artery through a mass of clots, with his left forefinger. Having commanded the artery, the clots were turned out, and a ligature passed. Unluckily the patient died of secondary hæmorrhage from the ruptured aneurysm. Possibly he might have recovered had a ligature been placed also below the aneurysm; but at all events, imminent death was averted, and life prolonged for twenty-four days. Edinburgh Med. Journal, Jan., 1858.

† *Med. Chir. Trans., vol. xvi.*

are joined by other veins of large size, so that no sharp instruments should be used in the latter part of the operation. It has been found in old subjects that the peritonæum has not escaped laceration, while being separated from its connections, even with the greatest care. Taking these circumstances into consideration, together with the fact that the artery may be shorter than usual, (it is very irregular), and that it may lie deep in the pelvis, several very excellent surgeons have expressed their conviction that under most circumstances it will be more prudent to tie the common iliac, although the direct supply of blood to the leg should be cut off.

The artery and vein are covered by, or surrounded with, a proper sheath. The ureter is, in some subjects, closely connected with the artery; usually it is placed internal and a little posterior.

The operation described for tying the common iliac is that by which this vessel may be the most readily reached, and it has the advantage of enabling the common trunk to be tied in case the operator should afterwards desire it. While the vessel is being secured, it should not be immoderately pulled, as the ilio-lumbar artery may be torn through. In all these operations the advantage of the patient being under the influence of chloroform, whereby respiration goes on tranquilly, and the descent of the intestines is to a great extent prevented, must be obvious.

We may add, that the aorta may be reached by the same operation by which the common iliac is tied, should it be necessary to do so, and that, as Mr. Guthrie suggests, it may be possible to reach either common iliac from the *opposite side* of the pelvis, should the position and size of an aneurysm render it impossible to do so on the same side. (See p. 770.)

IV. THE GLUTEAL ARTERY may be tied by placing the patient on his face, with the toes turned inwards, and making an incision from an inch below the posterior spinous process of the ilium, and an inch from the sacrum, towards the great trochanter. This incision should be about four inches long. The fibres of the gluteus maximus having been cut through or separated to the like extent, and a strong fascia beneath having been cut through, the vessel will be found emerging from the upper part of the sciatic notch. The SCIATIC artery may be found by making an incision through the same parts and for the same extent, but an inch and a half lower down. Both these operations are extremely difficult, from the great depth to which the dissection must be carried, the unyielding nature of the surrounding parts, and the hæmorrhage from the numerous blood-vessels that must necessarily be wounded. They should be attempted, however, in case of wounds; but for aneurysms of these arteries, it is necessary to tie the internal or common iliac.

SECTION IV.—THE FEMORAL AND ITS BRANCHES.

I. THE FEMORAL ARTERY extends from Poupart's ligament to the junction of the middle with the lower third of the thigh, where it passes

through the adductor magnus muscle into the ham, and receives the name of popliteal. Its course is as nearly as possible indicated by a line drawn from the middle of Poupart's ligament to the inner edge of the patella, supposing the knee to be bent and the thigh turned outwards. It is accompanied by its vein, which lies first to its inner side and then behind it, and still further down a little to its outer side. In its upper half it is covered by no muscle; in its lower half it is concealed by the sartorius, behind which it lies against the bone in a dense fibrous sheath, formed by an interweaving of the tendinous expansion of the adductor with that of the vastus internus. The long saphenous nerve, a branch of the crural, enters this tendinous sheath, and lies on the outer side of the artery. The saphena, the great cutaneous vein of the leg, the homologue of the cephalic in the upper extremity, ascends the thigh in a course parallel to that of the artery, but internal to it, and enters at the saphenic opening two inches below Poupart's ligament. In the case of stabs in the thigh, it is well to bear in mind the possibility that the profunda may be the vessel injured.* It arises from the femoral, about two inches below Poupart's ligament, and runs down the thigh behind and a little to the outside of the superficial femoral, and separated from it, first by the femoral vein, then by the adductor longus tendon. Aneurysm of the profunda is not unknown. Nor must surgeons forget the possibility of varieties in the femoral artery, and that there may be two branches of nearly equal size, instead of one trunk, or a large branch of the external circumflex given off from it.

The best place for the application of ligature, in cases of popliteal aneurysm, is the lowest part of the upper division of the artery, just before it is crossed by the sartorius. It is far enough from the aneurysm for the vessel to be healthy, and low enough to avoid embarrassment with the profunda.

* See the cases at p. 332 and p. 338.

To tie the Femoral Artery in its upper division.—The course of the vessel having been ascertained by its pulsation, an incision three or four inches in length should be made over it, about two or three inches below Poupart's ligament. The fat and superficial fascia must next be divided to the same extent. Some lymphatic glands will be met with here, and the saphena vein may be seen, but it generally lies much to the inner side of the incision. The fascia lata may now be divided to the same extent as the skin; the sartorius should be gently drawn outward (the sheath of this muscle should not be opened, as it would complicate the operation), and the pulsation of the artery felt for—its sheath should be opened at the lowest part of the wound sufficiently to admit the aneurysm-needle. There is always a risk of transfixing the vein and passing the ligature through it—an accident liable to be followed by fatal pyæmia. The best way of avoiding this accident, is to use a blunt aneurysm-needle, stiff enough not to bend; to pass it from the inner side, and to hold the inner cut edge of the sheath with forceps, and make it tense. Greater care will, of course, be necessary, if there has been an extension of inflammatory action to the sheath, with infiltration or thickening.*

To tie the Femoral Artery in the lower part of its course.—Turn the limb a little outwards, bend the knee, and raise the leg on a pillow. Make an incision three inches long, half in the middle third of the thigh, half in the lower, and in a direction midway between the front and back surfaces, through the skin and superficial fascia, taking all care to avoid the saphena vein. Divide the deep fascia on a director to the same extent. Now will be exposed the tendinous interweaving of the adductor muscles and vastus internus, that forms the tendinous sheath for the artery; which is covered with more or less areolar

* It may be mentioned as a fact, that in two patients, in whom Mr. Hayes Walton tied the femoral artery for popliteal aneurysm, after it had been subjected to pressure unsuccessfully,—in one instance for more than six weeks,—there were no structural changes in the parts that had been compressed.

tissue. At the outer part of the wound lies the edge of the sartorius muscle; this should be lifted and held outwards by a retractor. Then clear away the areolar tissue with care, and lifting up a portion of the aponeurotic sheath with the forceps divide it with the knife held horizontally. Introduce the director, and when the sheath is divided, the artery will very readily be found in a posterior position. The femoral vein is behind it. It is hardly necessary to allude to the possibility that the anastomotica magna might be taken up instead of the femoral artery: this branch arises from the trunk just before the latter perforates the adductor magnus to become the popliteal.

The ligature should be applied on the upper portion of the artery.

II. THE POPLITEAL ARTERY.—It is rarely necessary to tie this artery, but if called for it may be tied by cutting through the skin and fascia lata for the extent of three inches on the outer border of the tendon of the semi-membranosus muscle, the patient being placed on his face, with his knees straight. On pressing that tendon inwards, the artery may be felt. Its vein, which lies superficial and rather external to it, must be cautiously separated and drawn outwards, and the needle passed between them. This operation is very seldom performed. The writer witnessed an accident in the person of his friend Dr. Norton, by which it would be very possible for the popliteal vessels to be wounded. In drawing a tight cork, by means of a common corkscrew, from a bottle held between the knees, the bottle was crushed, and the sharp edges driven between the inner hamstrings and the bone into the popliteal space. The patient was most kindly and skilfully attended by Mr. Hodgson and Dr. E. Smith, and made a good recovery; but the hæmorrhage was immense, and the danger for a time great.

III. THE POSTERIOR TIBIAL ARTERY.—As we have often said, a wounded artery should, if possible, be tied at the wounded part; and in most cases the wound may be enlarged, and its track pursued till the bleeding vessel is reached. Yet there are exceptions to this latter rule; for example, the posterior tibial or peroneal artery may be wounded by a narrow instrument thrust through from the front of the leg; and to meet such cases, as well as others in which these vessels may require ligature for nævus, the surgeon must be prepared to cut down upon them from the calf.

To tie the Posterior Tibial in the upper part of the leg.—The course of the artery corresponds with a line drawn from the middle of the popliteal space to the middle of the space between the heel and inner ankle. The patient should lie on his back, with the injured limb resting on its outer side, the knee half bent, and the foot on a pillow, and the heel raised, in order to relax the muscles of the calf to the utmost.

Supposing the leg to be divided into thirds, an incision four inches long, half in the upper, half in the middle third, and an inch from the inner edge of the tibia, should be made through the skin and superficial fascia. When the calf is very large, the cut should be taken more than

an inch from the tibia, and less when the calf is very thin. If possible, the saphena vein should be avoided. In the illustration are shown two

converging branches of this vessel that were met with at the upper part of the wound. The deep fascia having been divided, and the muscles exposed, the edge of the gastrocnemius is to be drawn aside, in order to expose the soleus. The fibres of the soleus are next to be severed to the extent of the first incision, until the fascia covering its anterior surface is seen, and then this is to be pinched up, perforated, and divided on a director. The cellular fascia, which intervenes between the superficial and deep muscles of the calf, and surrounds the vessels, must now be torn through, and the artery will be exposed lying on the tibialis posticus. Its two veins, of uncertain size, are in very close con-

tact with it, and not unfrequently surround it by anastomoses. The nerve is superficial to, and sometimes a little on the outer side of the artery. If the artery is not readily found, and there should appear to be want of room to look for it, some of the fibres of the soleus may be cut across.

Instead of directing the soleus to be cut, some operators have proposed to separate its tibial origin from the bone. If this be done, the first incision should be made higher up, and nearer to the tibia. The objections to it are, that in case of injury, when the muscles are swollen and infiltrated with blood, it would be very difficult to distinguish between the attachments of the soleus and those of the flexor longus digitorum and tibialis posticus; so that all of the muscles of the leg might be detached, and the interosseous membrane reached, instead of the artery. Again, supposing the soleus to be correctly separated from the bone, it is no easy matter to draw the muscle sufficiently aside to expose the artery.

This operation is considered by Mr. Guthrie to be so "painful, difficult, bloody, tedious, and dangerous," that he proposes to reach the artery by making a perpendicular incision six or seven inches in length, at the back of the leg, through the skin, gastrocnemius, plantaris, and soleus; then the fascia will be exposed with the artery beneath it, and the nerve to the outer side or lying directly over it. Perhaps this operation cannot be spoken of in much more complimentary terms than the preceding one.

To tie the Posterior Tibial in the middle of the leg.—An incision must

be made three inches long, half in the middle third of the leg, half in

the lower, and midway between the inner edge of the tibia and the inner border of the tendo Achillis. It is often impossible to avoid cutting through the internal saphena vein. The fascia covering the edge of the tendo Achillis must be divided on a director. A second fascia, the deep one of the tendo Achillis, is often met with, and must be treated in like manner. Whether one or two of these structures be seen, depends on the line of the incision, for at a little distance from the tibia, the two are, to use an anatomical expression, blended. The artery, surrounded more or less by fat, which is a peculiarity in this situation, will be found along the inner edge of the flexor longus digitorum, accompanied by its two veins. The nerve is to the outer side. It must be remembered that, in the upper part of the leg, the posterior tibial nerve lies to the inner or tibial side of the artery; it soon, however, passes over, and inferiorly lies to its outer or fibular side.

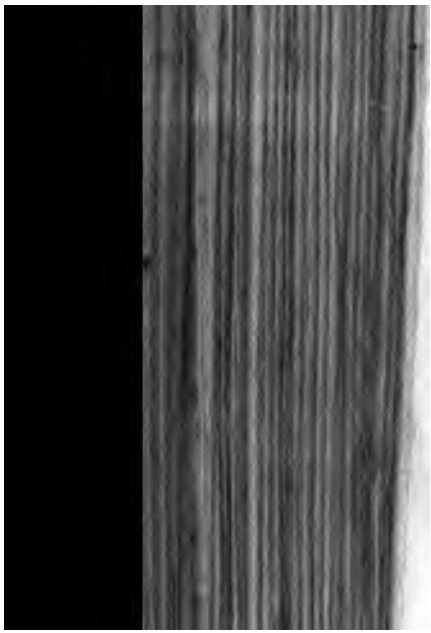
To tie the Posterior Tibial at the ankle.—The vessel is here comparatively superficial. An incision is made two and a half inches long, in the groove, midway between the anterior edge of the internal malleolus and the extremity of the heel, commencing near the tendo Achillis. The superficial fascia having been divided, the strong and dense fascia which adheres to the sheaths of the tendons, and covers the vessels and nerves in this situation (which is, in fact, the internal annular ligament), must be very carefully divided on a director, as well as the origin of the abductor pollicis; and the artery should be looked for, surrounded by the venæ comites. The following is the order of the muscles, vessels, and nerves in this situation:—The tendons of the tibialis posticus and flexor digitorum communis are close to the malleolus internus. At about a quarter of an inch external and a little more superficial, there is the posterior tibial artery, on each side of which is a vein; close outside is the posterior tibial nerve, and half an inch nearer to the heel is the tendon of the flexor longus pollicis. Much pains should be taken to avoid opening the bursæ around the tendons of the tibialis posticus and flexor longus digitorum respectively, or interfering with the sheath of the flexor longus pollicis. The line of incision advised is, on this account, to be preferred to that in a circular form around the malleolus, or that parallel to the tendo Achillis.

IV. The Peroneal Artery.—The trunk of this vessel is often absent, its place being supplied by branches from the posterior tibial artery. Sometimes, on the contrary, it is very large at the lower part of the leg, and supplies the place of the posterior tibial. To tie it, an incision should be made four inches long, almost in the centre of the leg, being about half an inch nearer the upper part, and an inch behind the external edge of the fibula. The border of the soleus is to be sought for and separated from the peronei which encircle the outer side of the fibula, and it may be requisite to detach a portion of this muscle from the fibula, to expose the flexor longus pollicis; the fibres of which must be separated longitudinally, first with the director, then with the handle of the scalpel, and the artery sought for about the centre, where it will be near the edge of the fibula. At the lower portion of the in-

cision, the vessel is covered by the bone. Directly that the flexor proprius pollicis is exposed, the great toe should be bent to the utmost, in order to relax the muscle and facilitate the separation of its fibres.

If in the case of wound, with arterial hæmorrhage, the posterior-tibial is cut down upon, and found intact, the incision may be extended, so as to allow the peroneal to be reached, by separating the superficial from the deep muscles of the calf, and raising the flexor proprius pollicis.

V. The Anterior Tibial Artery.—A line drawn from the head of the fibula to the base of the great toe will be parallel to the course of this artery.



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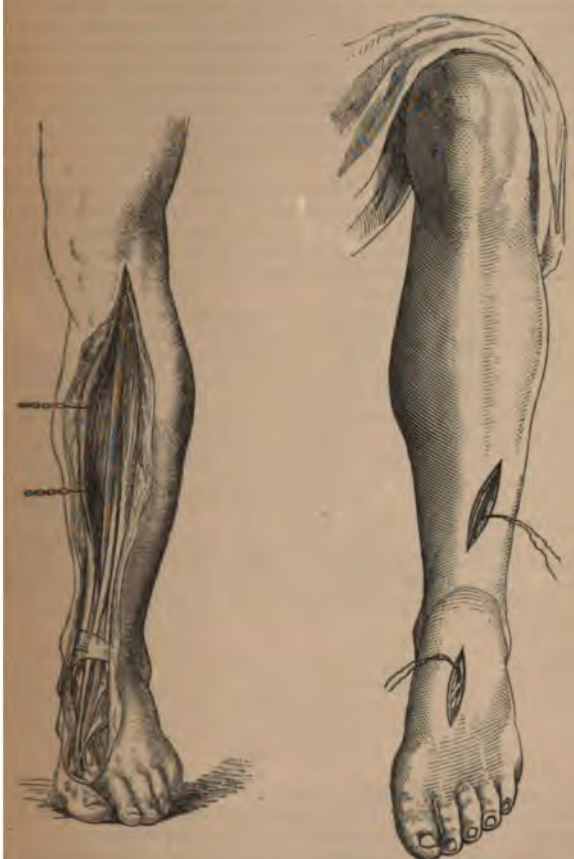
that fail, the posterior tibial artery may be tied behind the inner ankle, and the anterior tibial on the dorsum of the foot likewise, if



necessary. In wounds also of either of the tibial arteries inflicted on children in the operation of dividing the deep tendons for club foot,

pressure should have a fair trial; or Mr. Pollock's plan of compressing the femoral, and leaving the wound open to the air (p. 756).

We have described the various methods of *acupressure* (p. 333) proposed by Dr. Simpson as substitutes for the ligature. To these we ought to have added an account of Mr. Dix's *wire compress*.* Instead of pins he uses thin iron or silver wire passed by means of two straight needles round the artery, directly through the tissues of the flap to the surface of the skin, and then fastened over a cork by the ends twisted. Very little traction suffices to close the artery, and the wire can easily be withdrawn by cutting one end even with the skin, and making gentle traction upon the other end. Thread may be substituted for wire.

Mr. Wood has applied a double acupressure to the *continuity* of the smaller and superficial arteries to stop hæmorrhage and cure aneurysms exactly in the same way and by the same means as he uses to obliterate varicose veins (see p. 362), and has found the process all that could be desired, saving much pain to the patient, and much time and trouble to the surgeon.

It is to be hoped that surgeons will accept the fruit of Dr. Simpson's labours, and perfect the method of stopping the current of blood through arteries, whether in wounds, or in the continuity of the limb, by the simple means of thread, wire, and needles. Thus operations for exposing and tying arteries will be avoided; wounds will not be kept open by ligatures; so soon as the artery is closed, the thread or wire will be withdrawn, the sloughing of the tied portion will be done away with, and the consequent risk of pyæmia, as well as all the tediousness of waiting for the separation of ligatures. Care must of course be taken that the needle or wire do not strangulate the enclosed tissues, and thus prevent adhesion at that part.

We must lastly mention one of the greatest triumphs of modern medicine,—the cure of aneurysm of the abdominal aorta, by pressure kept up for five hours under chloroform. This, the first achievement of its kind, and the greatest, was the work of Dr. William Murray of Newcastle.†

CHAPTER VI.

AMPUTATIONS.

I. AMPUTATION OF THE THIGH.—It will be convenient to describe this amputation first; and to embody in the description of it such general precepts as are applicable to the other amputations.

In the first place, the surgeon should have his tourniquets, ampu-

* See Med. Times and Gaz., 24th Jan. 1863; also Professor Simpson's work on Acupressure, Edinburgh, 1864.

† Med. Chir. Trans., vol. xlvii.

tating knives, saws, artery-forceps and tenacula, ligatures, bone-forceps, sponges, long needles for acupressure, and short needles threaded (or *wired*), close at hand on a tray, arranged in due order; and he should see with his own eyes that every requisite is at hand before he begins.

In this, as in every other operation, it is necessary to place the patient in a convenient posture, so that the operator may not be obliged to stoop. For amputation of the thigh, the patient may be placed on a bed, or on a table covered with a folded blanket; the diseased leg should project sufficiently over the edge, and should be supported at the knee by an assistant, who sits on a low stool in front; and the sound limb may be secured to one of the legs of the table with a handkerchief.

For amputation of the thigh, in an adult, the surgeon should have a long, straight, sharp-pointed knife. Instead of the common amputating saw, he may, if he pleases, use the instrument depicted below, and invented by Mr. Butcher of Dublin, although it is in excision of the ends of bones that it is most particularly useful.

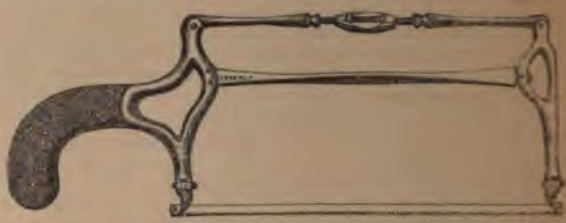
It will be seen that the blade, which is 8 inches long, and only ·25 inch in breadth, is most tensely stretched between two upright bars, by a screw in the middle of the uppermost cross bar. The tension combined with the fineness of the teeth renders it a capital cutter, whilst from the outset of the teeth, and narrowness of the blade, it cannot well become locked. Moreover it can, when the screw is reversed, be turned in any direction, and be there fixed, so as to cut backwards or sideways.*

Then measures must be adopted for compressing the main artery and preventing too great loss of blood. This may be done, either by pressure with the hand, or with the tourniquet.

Pressure with the hand on the main arterial trunk, if effected by a

* The saw depicted on p. 772 differs in some respects from that described by Mr. Butcher, Dublin Journ. Med. Sc., Feb., 1855. Weiss has another modification of it, suggested by Mr. Busk.

steady assistant who can be trusted, is sufficient in most cases; and if the limb is amputated so high up that the tourniquet cannot be applied, there is of course no choice; the femoral artery must be compressed



against the ramus of the pubes. Both hands should be used for this purpose. Either the thumbs, or else the tip of the fore, middle, and ring fingers in a line should compress the vessel, and when one hand relaxes a little, the other should press more firmly. The handle of a key covered with lint is sometimes used.

The *common tourniquet* consists of three parts: a pad to compress the artery, which should be firm, narrow, and flattish; a strong band which is buckled round the limb; and a bridge-like contrivance, over which the band passes, with a screw, by turning which the bridge is raised, and the band tightened. The pad should always be placed so as to compress the artery against the bone. Instead of a pad *attached* to the band, it is preferable to use a small, firm roller, about an inch thick; to put this lengthwise over the main artery, and secure it by a turn of bandage; and to apply the band of the tourniquet over this. The band should first of all be buckled tightly; then by turning the screw a very powerful degree of force is exerted. The screw may be put over the pad, or on another part of the limb; but it should always be put opposite the buckle of the band. The advantage of the tourniquet is, that it compresses the smaller arteries as well as the principal trunk; its disadvantage is, that it arrests the venous circulation, and causes a greater loss of venous blood; wherefore it should never be constricted tightly until the incisions are just commencing.

Amputations may be performed either, 1, by cutting from the skin towards the bone with a circular sweep of the knife, or with two oval semicircular sweeps; or, 2, by transfixion and cutting flaps outwards; or by a combination of either method. The advantages of the circular method are, a less surface of wound, a more clean and direct section of the vessels, and less liability to protrusion or uncovering of the end of the bone. Those of the flap are, its quicker performance (and with less pain when no anæsthetics are used), and the more perfect coaptation of the cut surface. The vessels, however, are apt to be cut or sliced obliquely, or opened in more places than one. The flap operation enables the surgeon to select a flap where he pleases, so that when the

flesh on one side of the limb is destroyed by disease or injury, the end of the stump may be covered with a flap taken almost entirely from the sound side, and greater length of limb may be preserved. But it is generally admitted that the circular produces better stumps.

The surgeon must be careful to have skin enough to cover the flesh, and flesh enough to cover the bone. If the bone is inclined to project it should be shortened at once; and the same with muscle or tendon, and especially with nerves, which should always be cut short if they project.

Mr. Teale, of Leeds,* declares that the mortality after amputations of the thigh and leg is nearly one in three; and that the stumps of those who escape are generally unsatisfactory, and unable to bear pressure. In order to diminish the mortality, and produce a more useful stump, he proposes to amputate by means of a long and a short rectangular flap. (See pp. 776, 781.) The long flap is to be formed out of such parts as do not contain the principal blood-vessels and nerves, and is to be long enough to fall easily over the end of the bone. Its length and breadth are equal to half the circumference of the limb: it is therefore a perfect square. The short flap is one-fourth its length. The long flap is folded over the end of the bone, and united by suture, as shown at p. 776. No dressing is used by Mr. Teale; and he orders the stump not to be lifted for many days. He believes the advantages of his plan to be, that tension is avoided by the ample size of the long flap; that this, folding over the end of the bone, soon acquires organic union with it, and seals up its veins; that the limb is not disturbed by lifting and dressing, and the veins consequently are early closed; and that the end of the bone is covered by parts free from large vessels and nerves, and that the cicatrix does not adhere to it.

In this, as in all other operations, we suppose the patient to be under the influence of chloroform; unless there is some rare and special reason to the contrary.

AMPUTATION OF THE THIGH. 1. *Circular Method.*—The surgeon stands on the outer side, and uses his left hand to grasp and steady the part which he is to amputate. The artery must be compressed by one of the methods before described, and an assistant must grasp the limb with both hands, so as to draw up the skin as high as possible. Then the surgeon commences by putting his arm under the limb, and makes an incision at one sweep, completely round the limb, through skin and fat down to the fascia. The knife of course cuts from heel to point. The assistant is now to draw the skin further up, the retraction being aided by a few touches with the knife; and then the knife, being put close to the edge of the retracted skin, is to be made to divide everything down to the bone by another clean circular sweep. The next thing is, to separate the muscles from the bone for another inch or two with the point of a knife, especially those most intimately connected with the bone; and then the periosteum having been divided by one more sweep, the muscles are to be well drawn up from the bone, either by the hands

* On Amputation by a long and a short Rectangular Flap, Lond., 1858.

of the assistant or by the *retractor*, a piece of linen with a longitudinal slit in it. The saw must be used to divide the bone: it should be held perpendicularly or nearly so: it should be used very lightly, and the last few strokes should be excessively short and gentle, that the bone may not be splintered. If it is, the irregular part must be removed by the forceps. The femoral artery should now be tied (if ordinary ligatures are used), its orifice being seized and slightly drawn out by forceps; and afterwards any large branches that appear in the muscular interstices. Then all compression should be *suddenly ceased*, so that any arteries that are liable to bleed may do so, and be tied at once. Hæmorrhage from large veins is to be restrained by elevating the stump, and making compression for a short time with the finger. If, however, nothing else will do, they must be tied. Any obstinate oozing from small vessels should be restrained by sponging with cold water, or perhaps by a touch with arg. nitras. So soon as bleeding has ceased, a light bandage may be passed round the limb above the stump, and the edges of the wound should be nicely adapted with sutures and a few long strips of plaster. The edges are to be brought together in a straight line, which may be made either perpendicular or horizontal, the latter, however, being the better plan.

The patient should then be removed to bed, and the stump be supported on a pillow covered with oil-cloth or gutta-percha. No other application will be needed save a good flake of fine wadding to exclude the air, and absorb discharge. Pain may be allayed by an opiate. The stump may remain as it is for some days, the cotton being changed, and the discharge wiped occasionally from its surface. But after from four to six days, sooner or later, according to the quantity of the discharge and the feelings of the patient, the dressings should be changed, the straps being taken off and replaced one by one, with care not to disturb the ligatures, and the hands of an assistant being employed to support the edges, and prevent their falling asunder. At the subsequent dressings, the points to be attended to are, to renew the light bandage occasionally, which was passed round the stump soon after the operation, in order to support the muscles, and prevent their retraction—to bring together the edges of the wound with adhesive straps, to press gently out all collections of matter, and take care that there is no *bagging*; —to use some antiseptic if need be—to remove the ligatures when loose—(that on the femoral artery should not be disturbed for a fortnight)—and to accelerate cicatrization by the nitrate of silver, or other stimulants, if the granulations appear languid.

If the patient is *very emaciated*, the circular incision may be carried down to the bone at once without ceremony, because in such patients the muscles always retract greatly. Sir C. Bell recommended the skin not to be divided quite circularly, but the knife to be inclined a little, so as to make two oval flaps. The same may be done also in dividing the muscles.

2. *Flap Operation.*—The flaps may be made, either from the inner and outer, or from the anterior and posterior aspects of the limb. The

former way is the more convenient if the amputation is low down; but the latter, if it is in the middle or upper third. In performing this operation in the latter way, the surgeon, standing as before, grasps the flesh on the anterior surface of the limb with his left hand, and lifts it

from the bone; then passes his knife horizontally through it—carries the point over the bone, pushes it through the other side of the limb as low as possible; then makes it cut its way out upwards and forwards, so as to make the anterior flap. In amputating the right thigh, the knife should be passed behind the saphena vein. It is again entered a little below the top of the first incision, passed behind the bone, brought out at the wound on the other side, and directed so as to make a posterior flap in the direction of the dotted line. Each of the flaps should be, in length, rather more than the semi-diameter of the limb at the point operated upon, and the posterior rather longer than the anterior to allow for the greater retraction of the hamstring muscles. Four inches is about the proper average length of the flaps from base to apex. Both flaps are now drawn back; the knife is swept round the bone to divide any remaining muscular fibres, and the bone is sawn through. In performing this operation Mr. Wood prefers to make the flaps oblique;—*i. e.* midway between the antero-posterior and lateral flaps, the *front* one being also a little *external*, and longer than the hinder flap. This secures a better drainage for the discharge, and insures that

* This cut represents the surgeon as standing on the inner side; it is, however, more convenient on the whole that he should stand on the outer side. The knife should be carried along close to the bone for an inch or more before it is made to cut the flap. Mr. Haynes Walton says that it is better to make the lower flap first, since thus, the integuments being relaxed, it is easier to shape out the upper flap accurately.

the cicatrix is behind the end of the bone; and therefore less liable to be galled in walking.

In the same manner flaps may be made from the inner and outer sides of the limb, the surgeon first grasping the flesh, and transfixing it, and cutting a flap on one side of the bone, then passing the knife close to the bone on the other side (without again piercing the skin), and making another flap.

3. *Teale's Operation.*—The surgeon is recommended to begin by marking out the flaps with ink. Taking the circumference of the limb at the point where the bone is to be sawn, half of this will be the length and breadth of the flap. One line is to be traced on the inner

side, as near as may be to the femoral vessels, without including them in the flap; a similar parallel line on the outer side, and a line of equal length joining their lower extremities. A transverse line may then be drawn to show the place of the short flap, which should be one fourth the length of the long one. "The operator begins," says Mr. Teale, "by making the two lateral incisions of the long flap through the *integuments only*. The transverse incision of this flap, supposing it to run along the upper edge of the patella, is made by a free sweep of the knife, through the skin and tendinous structures, down to the femur." But should the lower transverse line fall across the patella, the skin must be dissected off, and the cut be carried down to the femur, above its upper edge. "This flap is completed by cutting the fleshy structures from below upwards, close to the bone." The posterior short flap, containing the large vessels and nerves, is made by *one sweep* of the knife down to the bone; the soft parts being afterwards separated from the bone close to the periosteum, as far upwards as the intended place of sawing.

* This cut, copied from Mr. Teale's book, shows the flaps put together by sutures.

SECTION II.—AMPUTATION AT THE HIP-JOINT.

This operation is requisite in cases in which the upper extremity of the thigh-bone is smashed, and in which the soft parts are so injured that it is of no use to attempt excision. "No man," says Mr. Guthrie, "should suffer amputation at the hip-joint when the thigh-bone is entire. It should never be done in cases of injury when the bone can be sawn through immediately behind the trochanter major, and sufficient flaps can be preserved to close the wound thus made. An injury warranting this operation should extend to the neck or head of the bone, and it may be possible, as I have proposed, even then to avoid it by removing the broken parts." *

It is generally by flaps; either anterior and posterior, or lateral. The writer saw it performed in the year 1835 by Mr. Herbert Mayo at the Middlesex Hospital in the following manner:—

The femoral artery was first tied immediately below Poupart's ligament. This was the rule of that day, but was quite unnecessary. The artery should be compressed during the operation, and its cut orifice be tied immediately afterwards.

The patient being in the recumbent posture at the edge of the table, and the limb held out horizontally, a long knife was thrust through the limb immediately on the inner side of the joint, and carried forwards and inwards, and made to cut the inner flap from the adductor muscles. This flap should be immediately grasped by an assistant, who should compress the femoral artery.

In the next place, Mr. Mayo cut into the hip-joint with a short strong curved knife, and severed the ligamentum teres and the muscles attached to the digital fossa. Lastly, putting in the long knife over the trochanter, he cut downwards and outwards to make the outer flap.

This amputation, excluding the preliminary tying of the femoral artery, was most brilliantly accomplished in twenty-eight seconds; yet would scarcely in the present day be justified, since it was performed upon a young woman to get rid of neuralgia from a stump, which had undergone two previous amputations.

Of the method by anterior and posterior flaps, as practised by Mr. Liston, a very good example is afforded by a case of Mr. Tatum's at St. George's Hospital in July, 1855. The thigh having been slightly bent and abducted, the knife was entered at the outside at the junction of the upper and middle thirds of a line drawn from the anterior superior spine of the ilium to the great trochanter. It was carried obliquely inwards and downwards immediately in front of the joint, and brought out about two inches below the tuberosity of the ischium.

"Cutting my way out," says Mr. Tatum, "I made a large anterior flap, which was at once firmly grasped, so as to prevent the possibility

* Guthrie, Commentaries, 6th edit., p. 63.

of hæmorrhage, and drawn upwards. The anterior part of the capsular ligament being laid bare was easily divided; the head of the bone was then partially dislocated by rotating the limb outwards and extending it backwards; the ligamentum teres was at once cut through, and the dislocation of the thigh-bone completed. The knife was then carried through the joint and over the trochanter, and the posterior flap was made. In doing this I took care to have this flap somewhat small and thin, well knowing by experience that a large posterior flap tends by its weight to drag the cut surfaces apart in the progress of healing. As I completed the posterior flap, dry sponges were stuffed into the wound by assistants, and thus all hæmorrhage was at once stopped." Plenty of ligatures securing every bleeding vessel including the femoral vein; sutures and plasters, completed the operation. The patient, a lad of 16, left the hospital in a month.

In this case, as in one operated on by Mr. C. G. Guthrie, the entire thigh-bone was removed in order to give the patient a greater chance of security from the return of cancer than would have been given by amputation through the affected bone. In any such case, the surgeon probably will be able to plan his lines of incision as he pleases; and the limb can be moved in any direction, to facilitate his proceedings. Not so in cases in which there is extensive destruction of soft parts and smashing of the neck of the bone. Here the surgeon must be guided by the direction in which he can secure the best covering of skin.*

SECTION III.—AMPUTATION AT THE KNEE-JOINT.

This operation may be substituted for amputation in the lower third of the thigh, in cases in which excision of the knee-joint is impracticable.

1. *Syme's operation.*—A semicircular incision is made through skin and fascia over the patella; next, the knife is thrust horizontally across immediately behind the joint, and is made to cut a long flap from the calf of the leg; next, the anterior flap being lifted up, the extensor muscles are severed from the upper border of the patella; the remaining soft parts are divided, and the femur sawn through the condyles immediately above the joint.

2. If circumstances permit it, an anterior flap may be made including the patella, by a semicircular incision through the tissues in front of the joint, beneath the patella from the posterior part of one condyle of the femur to the other. Then the ligamentum patellæ is cut through, the patella lifted with the anterior flap, the joint opened by cutting through the lateral and crucial ligaments; and lastly, a sufficiency of under flap cut from the calf. The interarticular cartilages should always be removed, and the surface of the patella, or femur, if diseased. The popliteal artery should not be wounded above the part at which it

* For details of other modes of performing this operation, see Guthrie's Commentaries and South's Chelius, vol. ii.

is severed. The patella should be brought down over the end of the femur.

SECTION IV.—AMPUTATION OF THE LEG.

1. *Double flap Amputation at the upper fourth of the leg.*—This useful operation, practised by Mr. Syme and the late Mr. Liston, is performed a little below the knee-joint, the bones being sawn about

two inches below the tubercle of the tibia. It makes the most useful kind of stump for the labouring man, who is best accommodated with a stiff wooden or peg leg, since the pressure is borne by the callous skin and bone of the front part of the tibial tuberosity with the knee

bent as in kneeling. The stump being short, does not project behind beyond the socket of the leg, and is much less in the way than a longer stump. The operation is performed in the following way.

* This diagram represents the lines of incision in the double flap and oval amputations.

† Oval amputation, before the stump is put together.

A stout bistoury, with a blade four to five inches long, and a hand saw, are the only cutting instruments required. The flaps are made of integuments only by cutting from the surface without transfixion. The point of the knife is entered on the side about two inches below the tibial tubercle, and carried across the front of the leg, describing a curved flap rather longer than the half diameter of the limb, and of the exact width of the semi-diameter. The flap is then dissected up close to the bones and deep fascia. A flap exactly similar is then made on the posterior aspect (see diagram), and the integuments composing it are raised from the muscles. The latter, with the large vessels and nerves, are then divided transversely, direct to the bones. The bones are then equally sawn across. Mr. Syme usually commences by laying on the saw obliquely downwards to cut off the projecting corner of the tibia, and then reapplies it in a direct position. Mr. Liston occasionally excised the head of the fibula altogether at the same time; but this was found to open the knee-joint.

2. *Oval Amputation through the calf.*—An oval incision is made in the direction shown in the cut, through skin and fat; these are thoroughly drawn back; the incision is carried upwards obliquely through the gastrocnemius to the bones, so as to make a posterior flap; this being well pulled up, the remaining soft parts around and between the bones are divided; lastly, the bones are sawn through. The integuments are brought together in a transverse line. The objection to this method is, that from retraction of the muscles in the posterior flap, the front edge of the cut tibia may be left bare, and become necrosed, or give rise to a tender stump.

3. *The single flap operation* is performed by Mr. Fergusson in an elegant and expeditious manner, thus:—He first places the heel of the

knife on the side of the limb farthest from him, and draws it across the front of the limb, cutting a semilunar flap of skin; when its point has arrived at the opposite side, it is at once made to transfix the limb

* Single flap amputation; the limb transfixed.

this stage of the operation is represented in the figure below ; and then the posterior flap is cut. The surgeon must take care not to get his knife between the two bones. When the operation is performed high up, the popliteal artery will be divided instead of the two tibials. The tibia, however, should never be sawn higher than the tuberosity, or the joint will be laid open. The fleshy mass of the gastrocnemius may require to be cut out, to make the flap thinner. If low down, the *tendo Achillis* will require to be shortened after the flap is made. The flap is to be brought forwards, and confined by a stitch or two, the line of junction being horizontal.

4. *Circular Method.*—The artery being under command, as in amputations of the thigh, and the leg being placed horizontally, one assistant supporting it at the ankle, and another holding it at the knee and drawing up the skin, the surgeon makes a circular incision through the skin, four inches below the tuberosity of the tibia. The integuments are next to be dissected up for two inches, and turned back ; and the muscles are to be divided down to the bone by a second circular incision. Then a long slender double-edged knife, called a catline, is passed between the bones to divide the interosseous ligament and muscles, and both bones are sawn through together, the flesh being protected by a retractor, which should have three tails. The spine of the tibia, if it projects much, may be removed with a fine saw or bone nippers, and care should be taken not to leave the fibula longer than

the tibia, or it will give much trouble. The anterior and posterior tibial and peroneal arteries, and any others requiring it, being tied, the stump is to be treated as directed after amputation of the thigh. The integuments should be put together transversely.

5. *Teale's Operation.*—The length and breadth of the anterior flap are to be determined and marked out as before described, p. 776. The two lateral incisions are first made through the skin ; and the transverse one down to the bone ; then the long flap is dissected up, and with it, all the tissues in front of the bones and interosseous membrane ; includ-

* Teale's amputation of leg.

ing the anterior tibial vessels, which are divided once only. The short posterior flap is then made by one cut down to the bones, and is to be

dissected clean from the bones and interosseous membrane up to the point of sawing. The cuts are reduced from Mr. Teale's book.

SECTION V.—AMPUTATION OF THE ARM.

In amputations of the upper extremity, the flow of blood may be sufficiently commanded by compressing the artery above the clavicle, w

in the arm. If it is thought proper, however, the tourniquet may be applied so as to compress the artery against the humerus.

* Teale's amputation of leg.

1. *Circular.*—The arm being held out, and an assistant drawing up the skin, one circular incision is made through the integuments, which being forcibly retracted and detached from the deeper structures by a few touches of the point of the knife, and doubled back to the extent of an inch and three quarters, or more, according to the thickness of the arm, another is made down to the bone. These incisions should be made with slight divergences, so as to cut the skin and muscles rather longer in front and behind than at the sides. The subsequent steps are precisely similar to those in amputating the thigh.

2. *Flaps.*—The knife is entered at one side, carried down to the bone, turned over it, brought out at a point opposite (the vessels being left behind for the second flap), and then made to cut a neat rounded anterior flap two or three inches long. It is next carried behind the bone to make a posterior one of equal length; and is lastly swept round the bone, to divide any remaining fibres. The division of the bone, ligature of the arteries, and treatment of the stump as before.

3. It is occasionally advisable, in order to get as long a stump as possible, to amputate the upper arm with one long flap only, taken from the uninjured or healthy side. The method of doing this will vary with the case to be operated on, and may be left to the judgment of the surgeon.

SECTION VI.—AMPUTATION AT THE SHOULDER.

This may be performed in a great many ways. The most useful and the most usually employed are, 1. The patient being seated in a chair and well supported, or, which is better, being placed on a firm table, with the arm well raised, and projecting beyond its edge, and the subclavian artery being compressed, the surgeon enters a long, narrow, straight knife at the anterior margin of the deltoid muscle, an inch below the acromion. From this point he thrusts it through the muscle, across the outside of the joint, and brings out the knife at the posterior margin of the axilla. If the left side is operated on, the knife must be entered at the posterior margin of the axilla, and be brought out at the anterior margin of the deltoid muscle. Then, by cutting downwards and outwards, the external flap is made. The arm is then brought down to the side and forcibly adducted, the origins of the biceps and triceps, and insertions of the infra and supra spinatus are next cut through, and the joint is laid open. Finally, the blade of the knife being passed through the joint and placed on the inner side of the head of the bone, must be made to cut the inner flap.

2. The covering for the exposed part of the scapula in the preceding operation was obtained from the deltoid. But it may also be obtained from the muscles in front or behind, supposing the deltoid to be implicated in the disease or injury which demands the operation. One elliptical incision may be carried from beneath the middle of the acromion behind to the posterior border of the axilla, and another in front to the anterior border cutting through the deltoid down to the bone.

These flaps being dissected up, the capsule of the joint may be opened, the head of the bone turned out of the socket, and the remaining soft parts be divided; or the bone may be sawn through just beneath its neck. An assistant should be directed to grasp the flap which contains the axillary artery just before it is divided, because the pressure above the clavicle is generally not sufficient to stop the circulation entirely.

SECTION VII.—AMPUTATION AT THE ELBOW.

This is performed by passing the knife through the muscles in front of the joint, and cutting upwards and forwards, so as to make a flap from the fore-arm. Then the operator makes a transverse incision behind the joint. He next cuts through the external lateral ligament, and enters the joint between the head of the radius and external condyle, then divides the internal lateral ligament, and, lastly, saws through the olecranon, the apex of which, attached to the triceps, may be left in the stump, or may be afterwards dissected out.

SECTION VIII.—AMPUTATION OF THE FORE-ARM.

This operation should always be performed as near the wrist as possible.

1. *Circular.*—The limb being supported with the thumb uppermost, and an assistant drawing up the skin, a circular incision is made through it down to the fascia. When the integuments, assisted by a few touches of the knife, have been retracted as much as possible, and folded back all round for about an inch, the muscles are divided by a

second circular incision; the interosseous parts and the remaining fibres are next cut through with a catline; the flesh and the bones are then to be sawn through together, the saw being worked perpendicularly. The radial, ulnar, and one or two interosseous arteries require ligatures.

2. *Flaps.*—The limb being placed in a state of pronation, the surgeon makes a flap from the extensor side, just as is represented in the cut (p. 784); and he then transfixes the flexor side, and makes the other flap; taking care not to pass the knife between the bones whilst performing either transfixion. The interosseous parts are next divided, the flesh drawn upwards, and the bones sawn through. If the tendons project they must be shortened. Another way of performing the double flap operation at this point is to place the hand in a supine position and to cut the front flap first.

Teale's operation is performed, *mutatis mutandis*, like that of the leg; and that of the upper arm like the thigh.

SECTION IX.—AMPUTATION AT THE WRIST.

1. *Circular.*—The skin being pulled back, a circular incision is made a little below the level of the line that separates the fore-arm from the palm of the hand. Some little dissection will then be required to turn back the integuments as far as the line of the radio-carpal joint. The external lateral ligament is then cut through, and the knife carried

across the joint, to divide the remaining attachments. Finally, the styloid processes of the radius and ulna had better be removed with the cutting forceps, and the integuments brought together with sutures.

2. *Flaps.*—A semilunar incision is made across the back of the wrist, its extremities being at the styloid processes, and its centre reaching down as far as the second row of carpal bones. This flap being dissected up, the joint is opened behind, the lateral ligaments are cut

through, and the knife, being placed between the carpus and
the fore-arm, is made to cut out a flap from the anterior surfa
palm, as represented in the figure (p. 785). The tendons must
ened, the styloid processes removed, and the skin brought to
sutures. The radial and ulnar, and sometimes an abnorma
artery, will require ligature after this operation.

SECTION X.—AMPUTATIONS OF THE HAND.

I. AMPUTATION of the *fingers or thumb at their last joint*
performed thus:—The surgeon holds the phalanx firmly bet
finger and thumb, and bends it, so as to give prominence to th
the middle phalanx. He then makes a straight incision across
of the middle phalanx, so as to cut into the joint, and take
carry it deeply enough at the sides to divide the lateral li
The joint being thoroughly opened, the bistoury is carried
it, and made to cut a flap from the palmar surface of the last
sufficient to cover the head of the bone; and it is better to i
much than too little.

If, however, the joint cannot be bent, this operation may
formed thus:—The surgeon holding the phalanx firmly, with it
surface upwards, first passes his knife horizontally across the
the joint, the flat surface towards it, and cuts out the anter
then divides the lateral ligaments and the remaining attachme
one sweep of the knife.

II. AMPUTATION AT THE SECOND JOINT of the finger o
may be performed in the same manner.

III. It is always expedient to save as much as possible of th

and thumb; consequently, in cases admitting of it, flaps may be made from the soft parts wherever practicable, and then the bone cut with forceps. Teale's plan of making a flap from the dorsal surface has been adopted by Mr. S. Hey, with great advantage. In many cases a circular operation will preserve a longer stump than a flap.

IV. AMPUTATION OF A FINGER AT THE METACARPAL JOINT may be effected thus:—The surgeon should make out accurately the situation of the joint between the head of the metacarpal bone or knuckle and the base of the first phalanx. If he looks for the transverse lines on the palmar aspect, that mark the flexure of the joint and divide the finger from the palm, he may calculate that the metacarpo-phalangeal joint, at which he is to amputate, is about half an inch nearer to the wrist than this line is. Then he may begin by making a semilunar incision on one side of the prominence of the knuckle, a quarter of an inch beyond the joint, and should carry it round in front of the joint to the web on the other side, thus encircling two-thirds of the joint. The finger should now be drawn to the other side, the extensor tendon cut through, and the point of the bistoury passed into the joint, and made to divide its ligaments. This will allow the head of the bone to be turned out, so that the bistoury being placed behind it may cut through the remaining attachments and make another flap. This operation may also be performed by making an incision on one side of the joint (as in the method just described), and then bringing it across the palmar surface, and round the other side, to terminate where it began. The tendons and ligaments are now to be divided, and the head of the bone turned out. The digital arteries must be tied, and after bleeding has ceased, the wound may be closed by confining the adjoining fingers together. In patients for whom it is desirable to save the hand from much evident deformity, the head of the metacarpal bone should be cut off with the bone forceps, either instead of cutting through the joint or after this has been done. This enables the other fingers to be brought closer together after the amputation, so that the loss of the digit is less observable. Since, however, some of the strength of the hand is thereby sacrificed, this should not be done on the hand of a labouring man. Mr. Wood performs this operation by making two separate deep cuts with the bistoury on each side of the joint, meeting each other at each end, from the palmar to the dorsal aspect, and then severing the tendons and bone or joint.

V. AMPUTATION OF THE METACARPAL BONE OF THE THUMB may be performed thus:—The thumb being held out, a bistoury is inserted near the metacarpo-phalangeal joint, its point is thrust between the bone and the muscles of the ball of the thumb, and as close to the bone as possible, and brought out just above the articulation with the trapezium. This step is shown in Fig. 1. Secondly, the bistoury is made to cut its way outwards. Thirdly, an incision, beginning at the upper extremity of the last, is carried along the bone, and round and behind the metacarpo-phalangeal joint to meet the other incision at its commencement (see Fig. 2). Fourthly, the bistoury

should be passed along the metacarpal bone to clear it from its remaining attachments; and lastly, the bone should either be cut

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through, or disarticulated. If the latter proceeding is necessary, the bone must be forcibly abducted, and the ligaments on the inner side of the metacarpo-trapezial joint be cut through first.

2.

When the metacarpal bone of the thumb alone is diseased, it should, Mr. Fergusson advises, be extirpated alone, and its phalanges should be preserved. The bone should be exposed by means of an incision along its radial margin; then its articulation with the phalanges should be divided; and lastly, it may be turned out and separated from the tra-

pezium; taking care not to wound the radial artery where it passes between the first and second metacarpal bones.

VI. *Amputation at the head of a metacarpal bone* is effected by making an incision on each side of it (as in amputation of the fingers at the joint, but extending rather higher up), and then cutting through the bone with the cutting-forceps. Mr. Fergusson recommends the head of the metacarpal bone to be removed in almost every instance where the entire finger is abstracted, because the deformity is much less. But the part need not be removed high enough up to divide the transverse ligament. Care must be taken during the cure to keep the fingers parallel, and prevent them from crossing at their tips.

VII. AMPUTATION OF THE METACARPAL BONE OF THE LITTLE FINGER is performed thus:—An incision is made along the ulnar border of the dorsum of the bone, and is carried round the root of the little finger. The skin and flesh are dissected off, as closely as possible, and the bone divided or disarticulated. (See amputation of the metatarsal bone of the left toe.)

If a part or the whole of the shaft of one or any of the metacarpal bones is to be removed also, an incision should be made along its dorsum, to the point where the two former ones meet; and then the flesh being dissected away on either side, the bone may be cut through or disarticulated according to circumstances. In dividing the metacarpal bone in these amputations the forceps should have their handles inclined backwards, so as to slope the cut surface of the bone obliquely, and prevent a prominent angle above.

SECTION XI.—AMPUTATIONS OF THE FOOT.

I. AMPUTATION OF THE TOES at any of their joints is performed in precisely the same manner as amputation of the fingers. In removing a single toe from its metatarsal bone, the surgeon should take care first of all to ascertain the exact situation of the joint, which lies rather deeply. Moreover, he should not remove the head of a metatarsal bone, if possible to avoid it, because it is important to preserve the entire breadth of the foot.*

* Mr. Haynes Walton has favoured the writer with a valuable note to the effect, that it is desirable to explore the real seat and amount of disease about

II. AMPUTATION OF ALL THE TOES AT THEIR METATARSAL JOINTS—an operation which may be requisite in cases of frost-bite—is performed by first making a transverse incision along the dorsal aspect of the metatarsal bones, dividing the tendons and lateral liga-

2.

ments of each joint in succession; and then, the phalanges being dislocated upwards, the knife is placed beneath their metatarsal extremities, and made to cut out a flap from the skin on the plantar surface, sufficient to cover the heads of the metatarsal bones.

III. AMPUTATION OF THE METATARSAL BONE OF THE GREAT TOE is performed precisely like the operation for the removal of the metacarpal bone of the little finger. An incision down to the bone with a scalpel, is carried along its dorsum and round the root of the great toe, as shown in Fig. 1. Secondly, the knife, which must be kept as close to the bone as possible, is made to dissect it out from the surrounding parts; thirdly, the bone is cut through with forceps, a part of the operation shown in Fig. 2. Vessels are to be tied, and the wound

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the tarsus, before performing amputation. For example, he had a case in which the *head of the metatarsal* bone of the great toe was suspected to be carious and was condemned to be cut out; a serious operation, inasmuch as it takes away one of the three supports of the arch of the foot. But a free incision revealed disease in the first *phalanx* only. This was removed, and the patient recovered with the slightest possible limp.

ught together as shown in Fig. 3. It must be borne in mind that, lividing the metatarsal bones of the great or little toes, or the me-

1. 3.

arpal bones of the fore or little finger, care should be taken not to ve any prominent angle.

IV. AMPUTATION OF ALL THE METATARSAL BONES (*Hey's operation*) is performed in the following manner:—The exact situation of

the articulation of the great toe to the inner cuneiform bone (to which the tendon of the tibialis anticus may serve as a guide) being ascertained, a semilunar incision, with the convexity forwards, is made down to the bone, across the instep, from a point just in front of the aforesaid articulation, to the outside of the tuberosity of the fifth metatarsal bone. The flap of skin thus formed being turned back, the bistoury is first to be passed straight across the tendons and vessels so as to cut them a little shorter than the integuments, then to be passed round behind the projection of the fifth metatarsal bone, so as to divide the external ligaments which connect it with the cuboid. The dorsal ligaments are next to be cut through, and then the remaining ones, the bones being depressed. The fourth and third metatarsal bones are to be disarticulated in a similar manner, dividing their ligaments with the point of the knife, and taking care not to let the instrument become locked between the bones. The first metatarsal is next to be attacked, and lastly, the second, the extremity of which, being locked in between the three cuneiform, will be more difficult to dislodge. Perhaps it may be convenient to saw it across. When all the five bones are detached, the surgeon completes the division of their plantar ligaments, and slightly separates the textures which adhere to their under surface with the point of the knife, and then, the foot being placed horizontally, he puts the blade under the five bones, and carries it forwards along their inferior surface as far as the root of the toes, so as to form a flap from the sole of the foot sufficient to cover the denuded tarsal bones.

V. AMPUTATION THROUGH THE TARSUS, so as to remove the navicular and cuboid bones, with all the parts in front of them, is commonly called *Chopart's operation*. In the first place, the articulation of the cuboid with the os calcis (which lies about midway between the external malleolus and the tuberosity of the fifth metatarsal bone), and that of the navicular with the astragalus (which will be found just behind the prominence of the navicular bone in front of the inner ankle), must be sought for; and a semilunar incision be made from one to the other, as in the last-described operation. The flap of the skin being turned back, the internal and dorsal ligaments that connect the navicular to the astragalus, are to be divided with the point of the bistoury, recollecting the convex shape of the head of the latter bone. The ligaments connecting the os calcis and cuboid are next divided, and, lastly, a flap is to be procured from the sole of the foot. It may be expedient, after this operation, to divide the tendo Achillis if the heel is drawn backwards.

In these amputations the dorsal artery of the foot, and the external plantar or digital branches usually require ligature.

SECTION XII.—AMPUTATION AT THE ANKLE-JOINT.

I. SYME'S AMPUTATION.—The essence of this operation consists in the removal of the entire foot, and in preserving the integument of the

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heel as the most natural pad for the stump to rest upon. The incisions employed are different in the hands of various surgeons. But that generally adopted is represented in the cut (Fig. 1). The knife is carried round down to the bone. The ankle-joint is laid open in front, and its

* Syme's amputation. No. 1. The incision. No. 2. The flap after removal of the os calcis.

lateral ligaments divided. The os calcis is then dissected out, in which process, which is not easy, the knife should be kept close to the bone, so as not to wound the plantar arteries if possible. The malleoli are cut

2.

off smoothly, and if there is any disease of the ankle-joint, a thin layer of the end of the tibia should be removed; the posterior flap is then brought forward and retained by suture. The skin of the heel is rather liable to slough, and hence many surgeons make the incision more oblique, so as to preserve more skin from the dorsum of the foot, and less from the sole.

II. PIRIGOFF'S AMPUTATION is theoretically more perfect than Syme's, inasmuch as it is easier to perform, leaving a longer stump, better adapted to bear pressure; and does not disturb the tendo Achillis, nor, generally speaking, cause so much injury—nor is there the hollow flap. Instead of dissecting out the entire os calcis, this surgeon removes the anterior part of the bone, which supports the astragalus, and leaves the heel process, which forms a rounded, callous, and natural termination to the stump, and fits better into the heel of a shoe for the support of the body.

M. Pirigoff began his first incision* close in front of the outer malleolus, and carried it straight down to, and transversely across the sole of the foot, then obliquely upwards and forwards to the front of the inner malleolus. It divides everything down to the bone; and the incision is brought obliquely forwards on the inner side, in order not to cut the posterior tibial artery before its division into its plantar

* See a very good account of this operation by Mr. Spencer Wells, Med. Times, 20th March, 1858.

branches. The ends of this incision are connected by a second semilunar one across it into the ankle-joint, which is to be held with the foot extended. When the front of the joint is thus laid open, the lateral ligaments are divided; and then the posterior part of the capsule. Now with a narrow saw (such as Butcher's, p. 771) the os calcis is sawn through, from behind forwards and downwards. Then the malleoli are separated from the anterior flap, and sawn off, and a thin slice of the tibia if diseased. Lastly, the cut surface of the os calcis is brought into contact with the tibia; and the wound united with sutures. A very handy method of doing this operation is described by Pirrie, of Aberdeen. After the transverse cut across the heel, the saw is at once applied, and the os calcis divided from below upwards and backwards. The anterior cross-cut is then made a little above the ankle-joint, and the malleoli sawn off without opening the joint. The two cuts are then connected at their posterior corner by dividing the tendinous and ligamentous structures behind the joint. A very neat stump may be thus made very expeditiously.

SECTION XIII.—AFFECTIONS OF STUMPS.

I. It sometimes happens that the flesh shrinks away from the end of the bone, which becomes white and dry, and finally exfoliates. The nitric acid lotion is the best application.

II. PROTRUSION OF THE BONE is a very awkward circumstance. It not only greatly retards the healing of the stump, but produces a cicatrix which is thin, red, constantly liable to ulcerate, and unable to bear the least pressure or friction. The cause of the *conical stump*, as it is technically called, is generally a want of skin and muscle sufficient to cover the end of the bone. Sometimes, however, it arises from spasmodic retraction of the muscles, especially if they have not been properly supported by bandages during the cure. The remedy is simple; the bone must be shortened. This may be done in slight cases by making a longitudinal incision over the bone on the side opposite the vessels, and sawing off a sufficient portion of it, removing, at the same time, any diseased portion of the cicatrix. But if the projection is considerable the entire end of the stump must be amputated.

III. NEURALGIA of the stump is another very untoward event. It sometimes arises because the truncated extremities of the nerves (which after amputation always swell and become bulbous) adhere to the cicatrix, so as to be subject to constant compression and tension. Sometimes, however, it is entirely independent of any morbid state of the extremities of the nerves, but arises from some irritation in their course, or from some irritation, centric or excentric, of the spinal cord. Sometimes, again, no local cause whatever is detectable; and the pain is evidently connected with an hysterical state of the system. In any case the symptoms are extreme irritability and tenderness, paroxysms of violent neuralgic pain, and spasms and twitchings of the muscles,

which not unfrequently retract, and cause the bone to protrude, and the stump to become conical.

Treatment.—1. Painting with tincture of aconite, or Scott's ointment, F. 160, spread on lint, and worn as a plaster; or the emplastrum saponis or plumbi, combined with a little belladonna or opium; tonics and aperients, together with change of air, sometimes suffice to remove the extreme sensitiveness of these as well as of other irregular cicatrices. 2. If the pain and tenderness are referred to one or two nerves only, their bulbous extremities should be cut down upon and removed. 3. If, however, the whole surface of the stump is implicated, or if the stump is conical, a second amputation may be resorted to.

CHAPTER VI.

EXCISION OF BONES AND JOINTS.

I. EXCISION OF BONES.—We have already stated that bone when dead must be removed by operation, because nature seems not only to have provided no means of absorption, but the process of repair envelops the dead portion in a sheath of new bone that renders mechanical extrusion most improbable. We also intimated that bone when infiltrated with unhealthy lymph, and softened or carious, has but slow power of recovery, and that extirpation of the diseased part is advisable. Bone may also be invaded by cancer or other tumours, which render removal necessary.

Accordingly there are very few bones in the extremities which have not been removed wholly or in part, and many in the trunk and head. Operations for this end are usually exceedingly difficult and laborious, and are anything but attractive to the lookers on. When the existence of a tumour, or of diseased or dead bone is ascertained, and its extent explored by probes, if there are sinuses which admit of it, a sufficient incision is made through the thickened parts; and it must be made where the bone is nearest the surface, and where important vessels and nerves are not in the way. Then if there is a shell of new bone it must be bored with trephines, or cut with forceps, or chisel, or gouge; and when the diseased part is exposed, it must be removed as it best may. In cutting it out from any adherent tissues, the knife must be kept close to it.

Of the removal of portions of the *cranium*, and of the upper and lower jaw, we have already spoken. The clavicle has been extirpated by Mr. Travers for a tumour; by Mr. Davie because it pressed on the trachea. (See pp. 248, 311.) The *scapula* was extirpated by Mr. W. Fergusson from a patient who had previously suffered amputation at the shoulder-joint, and by Mr. Jones, of Jersey, for caries, leaving the arm still connected with the body, and forming a useful limb; it has

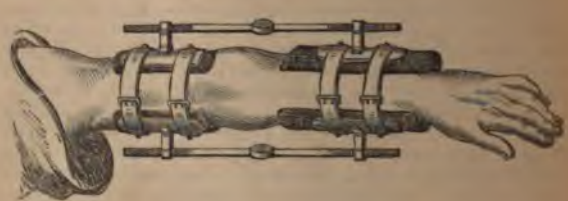
also been extirpated by Mr. Syme for tumours. It is laid bare by a ⊢ incision: the acromion sawn through, the levator anguli, trapezius, and serratus divided, the mass lifted, the neck of the bone sawn, and the deltoid and remaining muscles divided. The *sternum* is occasionally perforated, and removed piecemeal. The *ribs* when carious present no difficulty. The pleura is usually thickened, except in the case of tumours. Portions of the ossa innominata have been taken away. The *coccyx* may require to be cut out for disease, or for neuralgia; and for the latter malady it is sometimes necessary to make a subcutaneous incision, so as to isolate the bone from all the surrounding tissues. Portions of each of the long bones are removed from time to time. Mr. Jones has removed the *entire ulna*; the whole or greater portion of the fibula and radius, and considerable portions of the femur and tibia have also been taken away, in cases in which otherwise amputation would have been the only resource.

II. In like manner, in cases in which joints are hopelessly diseased, modern surgeons have substituted the cutting out the portions of diseased bone, for the cutting off the whole limb; and the results have been encouraging. It seems to be established, that excision is, on the whole, safer than amputation; less violence is done to the body, fewer great arteries and nerves are injured, and fewer large veins are divided. Lastly, the patient is left with an imperfect limb, it is true, but with one, which, in most cases, is highly useful. What we say of excision for disease, applies with double force to excision for injury.*

III. THE ELBOW JOINT is one, the excision of which has been now for some years an established rule. The operation is performed thus. The patient is on his back chloroformed, and the arm held out in a prone posture by two assistants, one of whom holds the upper arm, the other the fore-arm. An incision through skin and subjacent textures is then made on the ulnar side of the dorsum of the joint; its centre about the level of the olecranon; its length from two to four inches; and it should be so planned as not to go into the groove where the ulnar nerve lies. A second incision, parallel to this, is made on the radial side, and a third transversely, severing the triceps from the olecranon. The ulnar nerve is gently drawn inwards and protected, the lateral ligaments severed, the elbow forcibly bent, so as to turn out the ends of the bones. The olecranon may now be cut off with forceps, and then it will be seen clearly what other portions of bone

* A grenadier before Sebastopol received a wound in the popliteal space. All that was to be seen was a small orifice with inverted edges. On introducing the finger, the direction of the wound was found to be immediately forwards; pain was felt in the inner side of the head of the tibia, the joint was half bent, and could scarcely be moved. Hence it was presumed that the ball had lodged in the joint. On the third day amputation was performed. The ball was found impacted in the semilunar cartilage over the inner head of the tibia. On the third day after the amputation, secondary hæmorrhage from the femoral artery came on, and the patient quickly died. Dr. M'Cowan, who reports the case, says, very justly, that if excision had been performed as he himself had intended, at all events the immediate cause of the patient's death would have been avoided.—*Medical Times and Gaz.*, March 1, 1856.

are denuded, softened, or necrosed, and they may be cut off with forceps or saw. Mr. Fergusson's Lion Forceps, p. 483, will be of great service in steadying the extremity of bone which is being removed. As much as is necessary, and no more, of the brachialis must be cleared from the coronoid process. The lower end of the humerus is next dealt with; if it requires to be cleared from the soft parts in front, the knife must be kept close to the bone; then as much as necessary, and no more, may be cut off. Arteries are now to be tied, and so soon as bleeding has ceased, the wound is to be brought together by sutures, and the arm laid in a half-bent posture, either on an angular splint, well padded and covered with oiled silk, to which it is to be properly secured by bandages; or Mr. Butcher's box, with moveable sides, may be used; or Mr. Christopher Heath's splint, which secures, in the greatest perfection, the advantages of entire rest; the power of keeping the limb of any desired length, by means of the screws; the power of bending it to any angle by means of the central hinge; and the convenience of dressing the wound without disturbance. The cut explains itself.*



When the reparative stage has fairly set in, the joint should be moved from time to time to insure the formation of a flexible uniting medium or *false joint*.

There are many varieties in the plan of the incisions and the after steps of the operation which will readily suggest themselves. For instance, the incision may be a perpendicular one six inches or so in length—which is theoretically the best—or may be like X or ⊢, or

* See Mr. Heath's paper, Lancet, 28th Nov., 1857.

a simple curved flap from side to side; or beginning with a single | the surgeon may enlarge it to ⊢ or H as he sees occasion. *Gouge forceps* may be of service in these and other like operations.

IV. THE SHOULDER-JOINT may be exposed by making a perpendicular incision through the deltoid, three or four inches downwards from the acromion; and another from the extremity of the first incision upwards and backwards to the posterior border of the deltoid. The triangular flap, thus formed, is reflected upwards and backwards; the joint is laid open; the capsular tendons divided; the head of the humerus turned out and sawn off; and the glenoid cavity of the scapula, if diseased, may be removed by the bone-nippers or gouge. But as this operation is most frequently required in cases of gun-shot wound, the surgeon may vary his incisions, according to the extent and situation of the wound; and may make them of a V or T shape, or may make a simple curved flap, by cutting from near the coracoid process to an inch behind and below the root of the acromion.

V. EXCISION OF THE WRIST-JOINT.—This is an excision which has always been considered one of the least promising, because of the excessive complexity of the joints surrounding the diseased bones. Yet the surgeon will always do wisely to make every effort to preserve any part of the hand; for the removal of diseased parts cannot make the patient's case much worse, and there is always amputation as a last resource. The incisions and other steps of the operation must be various in almost every case, according to the place and extent of the disease, whether, for example, the ends of the radius and ulna, or the carpal bones only are diseased: no precise rules, therefore, can be laid down.

But the general principles should be those which guided Mr. Butcher of Dublin, during that operation on the carpus which is deservedly called by his name.* In this case the wrist-joint was excessively swollen, with numerous discharging sinuses around; the radio-carpal articulation grated on motion; a probe introduced into almost any sinus came into contact with roughened, crumbling, and broken-down bone; but the metacarpal bones and phalanges, the flexors of the fingers, and all the powers of the thumb were unimpaired. Having determined on operating, the first step was to make a curved incision, beginning a little below the wrist, two lines on the ulnar side of the extensor secundi internodii pollicis tendon, going down close to the carpal extremity of the metacarpal bones, and then sweeping upwards so as to finish below the end of the ulna fully half an inch higher than the point where it began. "The flap thus marked out," says Mr. Butcher, "was rapidly dissected up, and consisted of the integuments, areolar tissue, and extensor tendons of the four fingers, together with large deposits of fibrine." By the elevation of these soft parts

* On Excision of the Elbow and Wrist-Joints, and the Preservative Surgery of the Hand, by Richard G. H. Butcher, Esq., Surgeon to Mercer's Hospital, &c., Dublin, 1855. Also Reports in Operative Surgery, 3rd Series, Dublin Quarterly Journ., Med. Sc., Feb., 1859.

en masse the diseased bones were at once brought into view. In the next place, the soft parts were cautiously separated from the ends of the ulna and radius, including the second extensor tendon of the thumb, which was detached from its groove in the radius. Then the few ligamentous shreds which bound the diseased bones together were severed; their carious ends were made to project by bending down the hand; the soft parts in front were sufficiently detached by a few cautious touches with the knife, which was kept close to the bones so as not to injure the radial or ulnar artery; after this the ends of the bones were easily removed by Mr. Butcher's saw. Then the diseased carpal bones were dissected out, except the trapezium, which was sound; some of the thickened soft parts were cut away, the flaps laid down and secured, and the hand and arm put upon a padded splint in the prone position.

The advantage of Mr. Butcher's mode of operating is, that it leaves the extensor muscles of the thumb intact; so that although the fingers will be of necessity stiffened in a bent position, yet with the aid of the thumb they will be available for writing and many other purposes. In a recent paper he gives a specimen of the writing executed by a sightly and useful hand, which would formerly have been amputated.

Other modes of operating, consist of longitudinal incisions on one or both sides of the wrist-joint; or of incisions on the dorsal and palmar aspects so planned as to go between the tendons without dividing them. No two cases are exactly alike. But the principles which should guide the surgeon are to take away nothing that can safely be left, and to leave the soft parts of thumb or finger, even if obliged to cut out joints or portions of bones. It is useful also to bear in mind the fact which Mr. Butcher has pointed out, of the independence of the muscles of the thumb from those of the fingers, so that either set may be hopelessly injured by disease, leaving the other almost unaffected.

VI. EXCISION OF THE HIP-JOINT.—We have spoken in a former page of the removal of the carious head of the thigh-bone after it has become dislocated by disease, and of more or less of the diseased acetabulum with it. Now for a few words on the much more formidable operation which has been performed in cases of injury.

When the head or neck of the femur has been broken by a musket ball, the patient may be seen, says Mr. Guthrie, lying in bed, with a small hole in front or at the back of the thigh, with no bleeding, and no pain, and nothing but inability to move the limb and to stand upon it; and yet this man will die inevitably after a few weeks of pain and suffering, unless his thigh be amputated at the hip, or unless the splintered bones be cut out.

Mr. Guthrie, in the Addenda to his Commentaries, tells us that this operation was performed at least six times before Sebastopol, in 1855, and although not one of the patients survived, yet there were plenty of causes besides the operation to account for their death. Mr. Blen-

kins, Mr. O'Leary, Mr. Crerar, Dr. Hyde, and Dr. MacAndrew were the operators.

The surgeon may, according to circumstances, make a long, straight incision down the outer side of the limb, beginning a little below the anterior superior spine of the ilium, and going down over the trochanter. If room is not obtained by that incision, it may be enlarged by a transverse cut backwards either from the upper or lower end. The attachments of muscles having been severed from the trochanter, the bone is turned out of the wound by raising it at the knee, the shattered parts are sawn off, and the neck and head of the bone, if necessary, dissected out of the acetabulum. Or, the incision, as recommended by Mr. Guthrie, may be in the shape of a semilunar flap, beginning just over the inner edge of the tensor vaginæ femoris muscle, and curving downwards and outwards, so as to cross the bone at least an inch below the trochanter, whence it should turn upwards to the extent of about three inches. This flap, including skin, fascia lata, tensor vaginæ femoris, and part of the glutæus maximus, should be turned up, the muscles attached to the injured parts be divided, and the remaining steps of the operation be as before.

The experience of the American war is adverse to amputations for gunshot fracture, and very little more favourable to excision. Dr. Chisholm says he knows of two successful cases.*

VII. EXCISION OF THE KNEE-JOINT was first performed in 1762 by Mr. Filken, of Northwich, in Cheshire; it was subsequently performed twice by Mr. Park of Liverpool, twice by Sir Philip Crampton, and twice by Mr. Syme. One of Mr. Park's cases was eminently successful, so was one of Crampton's. Park's patient, who was a sailor, was able to go aloft and perform the usual duties of his calling.

Altogether, there are records of 19 cases performed by British and continental surgeons up to the year 1830. Of these 19 there were only about 8 recoveries; the remaining 11 died, but not all from the operation.†

From 1830 to 1850 the operation was in abeyance, and almost universally condemned by teachers of surgery, until, in the latter year, it was revived by Mr. W. Fergusson. Next to Mr. Fergusson, the late Mr. Jones of Jersey, whose success in all departments of operative surgery were remarkable; Mr. Page of Carlisle; the late lamented Mackenzie of Edinburgh, who lost his life in the Crimea; Dr. Pritchard of Filey; Mr. Evan Thomas of Manchester; Dr. Cotton of Lynn; Mr. Holt and Mr. Henry Smith, are entitled to the credit of having early performed this operation with success. Dr. Murray Humphry of Cambridge, and Mr. Butcher of Dublin, have also been frequent and successful operators. It is no disrespect to the living to add, that poor Price, had he been spared, might have excelled them all.

The *cases in which* it ought to be performed are, generally speaking,

* Manual of Military Surgery for the Use of Surgeons in the Confederate States Army, Columbia, 1864.

† Vide S. Cooper's Surgical Dict., art. Joints.

such cases of injury or disease as would otherwise be submitted to amputation in order to save the patient's life, or enable him to enjoy it.

The *object* of the operation is to produce a firm and useful limb, slightly shortened, and with entire bony anchylosis, or fibrous union admitting of some small degree of motion at the situation of the joint.

But all cases are not suitable for excision. And those cases are unsuitable, and better adapted for amputation, in which either the *quantity* of diseased bone requiring removal is very great—for then the

case will probably not do well—or if it proceed to recovery, and the patient be young, the future growth of the limb may be prevented; or the *quality* of the disease may be such as experience has shewn to be incompatible with the exudation of healthy material of repair.

This last is a point which has been very clearly stated by Mr. Price.† If the "white swelling" has begun with disease of the synovial membrane (see pp. 289, 298) or so-called ulceration of cartilage, the diseased joint surfaces may be cut off, and the case

* The above drawing represents a patient of Mr. Price's, a young woman æt. 26, whose left knee was excised in October, 1856. The patella was retained; but was cut out after a year, because abscesses continued to form around it. "The limb," says Mr. Price, August, 1859, "is most serviceable, and the girl is active employment."

† Contributions to the Surgery of Diseased Joints, with especial reference to the Operation of Excision. No. 1. The Knee. By P. C. Price, Surgeon to the Great Northern Hospital, &c. &c., Lond., 1859.

o well; or if there be decayed scrofulous exudation, *tubercular* is called, into the bone structure, and it be in one or more *scribed* masses, bounded by a layer of lymph and healthy bone, nasses, when laid bare by the section of the bone, may be gouged a dentist would deal with a carious tooth, and if sound bone be case will do well.

so, if, as Mr. Price remarks, the scrofulous exudation be *diffused* hout the cancellous tissue; if the whole area of the bone be d and softened, with its cancelli filled with strumous deposit.

periosteum thickened and separating. In such a case, the whole can scarcely be removed, and diseased bone is left, incapable of exudation. Low inflammation, repeated abscesses, and fresh ons to remove carious or necrosed fragments will be the almost result, and if the patient do not die of exhaustion or pyæmia, t go through amputation at last.

it may be observed, that since there are no absolute diagnostic f the various forms and degrees of joint disease, it may happen e surgeon must sometimes come to a final decision after he has

s represents a boy, aged 9, whose knee was cut out by Mr. Price, July for a time he did well, but never had good use of the limb, which at of two years and three months presented the appearance shown above. was then amputated, and he recovered. After the amputation, the the bones which had suffered excision were macerated, and are repre- n the next cut. Evidently the causes of failure were the intensely s diathesis, the softened and unhealthy state of the bones, and the n of numerous abscesses in the soft parts, which had been the seat of ur four years before the excision. See Lancet, Nov. 27, 1858.

laid the joint open, and has removed a slice of bone. This point is clearly laid down by Mr. Butcher.* The patient, whilst under chloroform, suffers no prolonged shock; and if the bones are found extensively diseased, amputation should be performed at once. Mr. Fergusson has done this; and Mr. Hutchinson, a surgeon no less remarkable for his own successful operations, than for his zeal in collecting accurate statistics. The latest views of Mr. Fergusson, as expressed in his lectures at the Royal College of Surgeons, in June, 1864, incline, however, rather to re-excision (or re-section as he terms it) than to amputation after unfavourable results from the first operation. In operating on a case which appeared to be suitable for excision, Mr. Hutchinson found the cartilage gone, the joint surfaces carious, deep ulcers excavated in the patella and tibia, the cancellous structure of the femur infiltrated with yellow matter, and containing an ill-circumscribed abscess; and a second slice revealed no better state of things. Amputation, therefore, was immediately performed. The patient had lost nothing by the attempt to save his limb; and Pedantry only, complaining of such as "disturb her ancient melancholy reign," could object to the proceeding.

The *operation* consists, first, of one or more incisions for laying bare the joint. Mr. Fergusson usually makes an H incision in front of the joint; the lateral lines about four inches long; the cross cut running below the patella. The lateral should, as Mr. Butcher says, be placed far enough back to allow the discharge to run out freely, and prevent pouching of matter in the ham. Other surgeons have made a single semicircular flap, running below the patella, with upward extension

* Second Memoir on Excision of the Knee-Joint. Dublin Quart. Jour. Med. Science, Feb., 1857.

at its ends, or a straight cut across, close below the patella, dividing the lateral and anterior ligaments.

The next point is to raise the flap, including the patella, bend the joint, sever the lateral ligaments, very cautiously lay bare the popliteal surface of the femur, and cut off the articular surface. Here Butcher's saw will be useful, cutting from behind forwards. The cut should be parallel with the natural surface of the condyles, and all obliquity should be avoided, so that the sawn surfaces of bone may rest flat and evenly against one another. Then any carious spots must be gouged out, or, if need be, another slice removed; and now, too, the surgeon may convert his operation into an amputation if the state of the bone seem irreparable.

The tibia is then treated likewise. The patella, if healthy, may have its cartilage pared off: if ulcerated a little, the diseased surface may be cut out: if thoroughly soft and strumous, or even if doubtful, it should be removed. Perhaps it is the best plan always to do so. Then all diseased synovial membrane, and all thickened and infiltrated areolar tissue, should be trimmed off, so that the tissues which remain, both hard and soft, may be as healthy as possible. This is one of the points on which success depends.

The next thing is to tie vessels and remove clots. Mr. Hutchinson recommends that an opening should always be made to the outer side of the vessels through the skin covering the popliteal space, to act as a drain to the suppuration which generally pockets in the popliteal cavity after this operation.

The surgeon may then bring the limb into a straight position; which is to be accomplished by extension, under chloroform, from the foot, whilst the thigh is held steadily; and as this may be a matter of some difficulty, it may, as Mr. Butcher observes, be facilitated by division of the biceps and other ham-string tendons. This will insure greater freedom from displacement and spasmodic jerking. The cut surfaces of bone should be accurately adapted to each other; and here Mr. Butcher gives the caution to let no soft tissue be allowed to intrude between them. The edges of the flaps are brought together with sutures, and covered with lint or cotton.

In the next place the limb must be *put up;* and it is upon the details of this, and of the after-treatment, that the patient's safety will mainly depend. The wounded surfaces of bone must be in apposition, and at absolute rest; all possibility must be excluded of their slipping, starting, grating, jerking, or grinding against each other, or of the femur projecting. If they do, the exudation of repair must of necessity be destroyed and decomposed; and fetid suppuration, and possibly purulent absorption, or caries, will result.

It is universally agreed that the limb should be put up on the operating table before removal to bed. The leg should be nicely bandaged, and the hollows above the ankle padded. The engraving will show the solid look of a limb, after this operation, done up in the box employed by Mr. Butcher. It is well padded with horsehair; the sides can be

let down by hinges, so as to give access to the wound: in other respects the cut explains itself.*

Mr. Price, who with Mr. Parkinson and Mr. Heath, had great opportunities of perfecting the details of treatment in Mr. Fergusson's case in the King's College Hospital, before he executed his own operation, used a McIntyre's splint, of thin tinned iron, with a footboard. The length can be regulated. The portion corresponding to the popliteal

space is slightly convex upwards, so as to keep the bones in their place: and is narrow, so that the wound can be got at. There is an interval between the leg plate and footboard, in order that nothing may press on the heel or tendo Achillis. The foot and leg are confined by rollers to this splint, previously well padded with wool covered with oiled silk; and with additional pads of the same, where needed, especially behind the head of the tibia. A short splint should be laid on the front of the thigh, and compressed by a web and buckle.

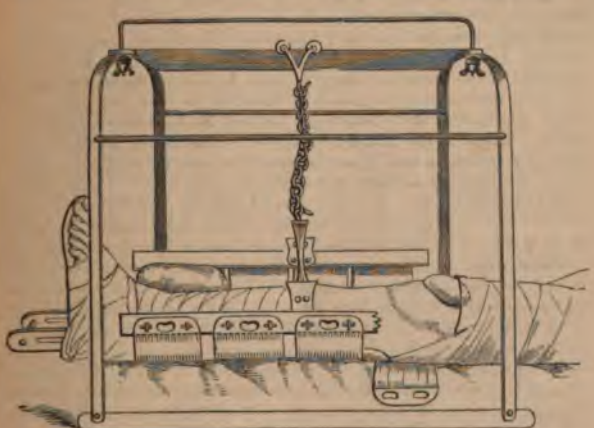
Then on the outside of this apparatus is used a long side splint, the central part of which is replaced by an iron hoop. It passes up the side, and is provided with a perineal band, as usual (p. 278). Lastly, the whole limb, so put up, may be swung in Salter's apparatus, as represented in the following drawing made from the life by Dr. Westmacott, from a patient of Mr. Price's in the Great Northern Hospital. The wounded part is uncovered, and the side splint removed, and part of the swing undone to show it. The practical fact is, that the dressings had been duly attended to, that the limb had never been disturbed since the operation, and was convalescent in the fifth week. The draw-

* Case of Excision, Dublin Quarterly, Nov., 1857.

ing shows a small pad placed on the femur, to keep the end of it from tilting forwards.

During the first few hours, the patient, as after every other operation, should be watched by a surgeon, to guard against shock, vomiting, spasm, and hæmorrhage. The end aimed at in the operation has been described; the time which is required to produce it is uncertain; but after five or six weeks the limb may often be lifted, and the patient go on crutches, with the firm confidence that after some months he will have a strong and useful limb, adequate for any active employment. To complain of the time required to rescue a patient from mutilation, and give him a useful leg, is absurd.

Numerical Results.—From the revival in 1850 to December 1854, 31 cases had been collected by Mr. Butcher; from that time to December 1856, when he published his second memoir, 51 additional cases; altogether 82; by the end of December 1858, Mr. Price had collected 79 besides, making 160 in all. Of the 160, 32, or 20 per cent. died; of whom 8 died of pyæmia, and 1 of erysipelas; these are *hospital causes*. Exhaustion, irritation, and shock destroyed 15; acute phthisis, peritonitis, pneumonia, suppression of urine, and dysentery each destroyed 1; 1 died after amputation; 2 from unknown causes.



In 18 cases, one of which was fatal, amputation was obliged to be resorted to, for non-union, abscess, and hectic.

In at least 50 per cent. the operation resulted in a good useful limb.

It must be added that since that time, Mr. Price collected particulars of nearly 250 cases by various operators, of which

the fatal results have, in his estimation, been about at the same average as after the operation of amputation of the thigh. But much of the mortality, and the necessity for amputation, depend upon causes which surgeons in time will think it a disgrace to let patients suffer from, especially hospital air. Out of 40 cases operated on by Mr. Fergusson at King's College Hospital, up to June 1864, no less than 15 terminated fatally,* chiefly from pyæmia and exhaustion. Of 30 cases published by Dr. Humphry of Cambridge, 6 died, of whom 3 suffered amputation, and 24 recovered, of whom 5 suffered amputation, leaving 19 recoveries from the excision simply.†

VIII. EXCISION OF THE ANKLE-JOINT AND TARSUS.—In disease and injury of the ankle-joint and tarsus, the surgeon should still be guided by the principles upon which he acts in disease of the wrist; namely, that diseased parts should be extirpated, and that any sound parts that may even be partially useful should be left. The operation in every case must be planned according to the state of the parts; and in most cases the surgeon will probably content himself with enlarging sinuses, denuding the diseased bones, and scooping them out piecemeal with the gouge, and repeating the operation if necessary until all the carious parts are removed, instead of removing the whole at one coup.

The *os calcis* has been cut out by Mr. Hancock, Mr. Gay, Mr. Page of Carlisle, and other surgeons. Mr. Page began with an incision down to the bone, from half an inch below the inner ankle, directly under the sole of the foot to the outer ankle; intending to resort to Syme's operation if the state of things revealed by future dissection should render it necessary. The flap was dissected up from the heel; the tendo Achillis cut at its insertion; the joint between the os calcis and astragalus opened, the interosseous and other ligaments divided. The incision was then carried forwards along the sole, on each side, and a flap raised from the anterior part of the os calcis, up to its articulation with the cuboid, which was then divided, and the os calcis removed.‡

The *cuboid* bone may be laid bare by a crucial or H incision, and may be gouged out or separated from its connections by forceps and knife.

The *os calcis* and *astragalus*, with the *cuboid* and *malleoli*, were removed by Mr. Thomas Wakley in 1847.§ An incision was carried across the sole of the foot from one ankle to the other. A second and third at right angles to this along each side of the sole, so far forwards as the calcaneo-cuboid and astragalo-scaphoid joints respectively, so as to enable a flap of the sole about two inches long to be turned forwards. Then a last semicircular incision was made from one ankle to another behind the heel at the level of the insertion of the tendo Achillis, which was cut through. The flap made by this last incision was raised, and the os calcis disarticulated from the astragalus and cuboid, and re-

* Lectures at the Royal College of Surgeons, July, 1864.

† Address before the British Medical Association, August 5, 1864. Med. Times and Gaz., Aug. 13, 1864.

‡ Lancet, 1860, vol. i., p. 628.

§ See report and drawings in Lancet, 1848, vol. ii., p. 5; also in Gathrie's Commentaries.

moved together with the integument covering it, which was included between the incisions. Then the astragalus was detached from the tibia and fibula, with great care not to wound the anterior tibial artery. The astragalus was next detached from the scaphoid, and the malleoli were removed with forceps. The posterior tibial artery was tied. The patient recovered, with a fair use of the foot.

The front half of the *cuboid*, with the *bases of the 4th and 5th metatarsal* bones, were removed by Mr. Wood for caries of long standing in the summer of 1864, at King's College Hospital. The patient made an excellent and rapid recovery, with no deformity beyond a small scar, and with excellent use of the foot.

APPENDIX OF FORMULÆ.*

§ 1. Tonics, Stimulants, Narcotics, Anodynes.

F. 1. *Cinchona with Acid. Light Tonic.*

℞. Acidi sulphurici diluti ℥v.—xv.; syrupi aurantii ʒss; infusi cascarillæ (*vel* decocti cinchonæ), fʒx. Misce, fiat haustus, ter die sumendus, ante cibum.

For Children.

℞. Decocti cinchonæ lancifoliæ fʒiijss.; syrupi zinziberis fʒss. acidi sulphurici diluti ℥xxx. Misce, sumatur pars quarta ter die.

2. *Quinine Draught with Ammonia.*

℞. Quinæ disulphatis gr. ij.; tincturæ opii ℥ij.—v.; spiritûs ætheris compositi, spiritûs ammoniæ aromatici ãã fʒss.; decocti cinchonæ fʒx. Misce, fiat haustus, ter vel quater die sumendus. *In cases of great Debility, with Restlessness or low Delirium.*

3. *Quinine Draughts with Acid.*

℞. Quinæ disulphatis gr. ij.; acidi sulphurici diluti ℥v.—xv.; tincturæ aurantii, syrupi ejusdem, ãã fʒss.; aquæ fʒjss. Misce, fiat haustus, ter die sumendus.

℞. Quinæ disulphatis gr. ij.; acidi hydrochlorici ℥x.; camphoræ gr. ij.; spiritus ætheris nitrici fʒj; tincturæ cardamomi compositæ fʒj.; aquæ menthæ viridis fʒx. Misce, fiat haustus, sextâ quâque horâ sumendus. *A powerful stimulant and tonic.*

N.B. To make a *clear* quinine mixture with infusion of roses, the infusion must be made with *nitric acid*, as in F. 119.† (*Squire.*)

Quinine without Acid.

℞. Quinæ disulphatis grana xxxij.; acaciæ pulveris grana lx.; syrupi zingiberis fluiduncias iv. Misce. *The quinine not being dissolved in acid has much less taste. One teaspoonful contains one grain of quinine.* (*Parrish.*) See also F. 8.

* The preparations are those of the London Pharmacopœia unless it is otherwise expressed.

† N.B. The word *Squire* appended to a Formula indicates a quotation from Squire's 'Companion to the British Pharmacopœia;' 2nd edition. The word *Parrish* indicates quotation from Parrish's 'Treatise on Pharmacy.' Philadelphia, 1864.

℞. Quinæ disulphatis grana xxx.; mucilaginis acaciæ, aquæ singulorum fluiduncias tres. *This is a good form when we desire to* cinchonize *a patient. In syphilis* (see p. 219), *in any inflammation whatever when strength is failing and irritability increasing spite of antiphlogistic measures, and in all inflammations, rheumatisms, &c. of malarious origin* (see p. 414), *five grains of quinine may be given every two, three, or four hours till the ears ring. Also in certain stages of phthisis, cancer, &c., when rapidly advancing with great pain. See Surgeon Major Hare's Paper on Malarious Fever*, Med. Times and Gazette, vol. ii. 1864. *Also Squire.* Glycerine ʒij. may be added.

Parrish's Quinine Pills.

℞. Quinæ disulphatis gr. xx.; acidi sulphurici aromatici minima duodecim. Drop the acid upon the quinine, mixing with a spatula; seize the moment when the mass is of proper consistency and divide into four pills; each of which will contain five grains of quinine, and will not be too large. Sulphate of quinine may also be made into pills, by adding one grain of glacial phosphoric acid, or a ½ gr. of tartaric acid, to each grain of quinine.

4. *Liquor Cinchonæ.*

℞. Liquoris cinchonæ flavæ *Battley* ♏xx.; aquæ pimentæ fʒj. Misce, fiat haustus quater die sumendus. *In atonic erysipelatous diseases.—A prescription of Dr. Farre's.* One fluid drachm of Battley's solution is said to be equal to an ounce of the finest bark. The *infusum cinchonæ spissatum* of the London Pharmacopœia, or the extractum liquidum of the British Pharmacopœia, may be used instead; but we see no reason why the names of Battley and Farre, who devised these preparations, should be let drop.

5. *Bark with Ammonia.*

℞. Decocti cinchonæ flavæ fʒviiss.; ammoniæ sesquicarbonatis ʒss.; syrupi zinziberis fʒss. Misce. Dosis, pars sexta, bis vel ter die.

6. *Bark with Liquor Potassæ.*

℞. Decocti cinchonæ flavæ fʒviiss.; liquoris potassæ fʒij.; tincturæ cinchonæ compositæ fʒij. Misce. Dosis, pars sexta, bis vel ter die.

7. *Bark with Guaiacum.*

℞. Tincturæ guaiaci ammoniatæ, tincturæ humuli ãã fʒss.; decocti cinchonæ lancifoliæ fʒij. Misce, fiat haustus, ter die sumendus. *In chronic rheumatism, chronic rheumatic sclerotitis, &c.*

℞. Tincturæ guaiaci ammoniatæ, tincturæ cinchonæ compositæ singularum fʒj. Misce. Dosis, fʒij. bis die e cyatho lactis. *In chronic rheumatism or constipation with debility.*

8. *Syrupus Quinæ.*

℞. Quinæ citratis gr. iv.; syrupi simplicis fervefacti f℥j.; olei essentialis amygdalarum amarum guttas ij. Misce. Dosis, fluid-drachma bis vel ter die. *A very elegant preparation devised by the author. The flavour of the bitter almonds hides the bitter of the quinine. A few grains of tannin hide the bitterness of quinine.* (*Parrish.*)

The various secondary alkaloids, produced from cinchona bark, as the *amorphous quinine*, the *cinchonia*, quinidine, &c., &c., are well deserving the attention of practitioners. *See Clements R. Markham's Travels in Peru.*

9. *Sulphate of Zinc Mixture and Pill.*

℞. Zinci sulphatis gr. vj.; acidi sulphurici diluti ♏xxx.; syrupi aurantii f℥ss.; infusi aurantii f℥vss. Misce, sumantur cochlearia duo ter die.

℞. Zinci sulphatis gr. xij.; extracti anthemidis ʒss. Misce, et divide in pilulas xij.; quarum sumatur una vel duæ ter die. *A good tonic when steel is of doubtful propriety; and in oxaluria after purgation.*

Dr. Robert Dickson's Pills of Oxyde of Zinc.

℞. Zinci oxydi, grana quatuor: ext. gentianæ, granum. Misce, fiat pilula ter die sumenda. *Dr. R. Dickson has found this remedy of great service in the profuse perspirations of phthisis.*

PREPARATIONS OF IRON.

10. *Quevenne's "Fer Reduit."*

℞. Ferri redacti P.B. granum; sacchari lactis granum; fiat pulvis, linguæ imponendus, inter cibum, ter die.

Iron Filings.

℞. Ferri limaturæ puræ granum; mannæ, saponis, theriacæ, vel extracti glycyrrhizæ quantum satis sit, ut fiat pilula, ter die sumenda.

When iron is administered slowly and gently in order to produce a gradual improvement of health, the metallic iron, in the form of iron filings, answers perfectly well. Or Quevenne's iron reduced by hydrogen may be substituted as more refined, although it often becomes oxydized before it is swallowed. The old black steel wine from Apothecaries' Hall, *and the various preparations of carbonate and oxyde, answer much the same purpose.* Although iron improves the quality of the blood in the right cases, we are not warranted in supposing that this is due to absorption of the metal, but much more likely, to its action on the mucous membrane. Hence the practitioner, in choosing his preparation, should decide whether he chooses to give a rapidly acting and powerful styptic preparation, such as the chloride, or a mild one. The salts with vegetable acids, the phosphates, and lactates are shown by experience to be the least annoying. Dr. Mark

told the writer that Sir H. Halford used to combine ginger or capsicum with steel, when it was "heavy" for the stomach.

Ammonio-chloride.

℞. Ferri ammonio-chloridi gr. xx.; tincturæ zinziberis f℥ij.; ammoniæ sesquicarbonatis ℈j.; syrupi f℥ss.; aquæ destillatæ f℥vss. Misce. Dosis, f℥j. ter die. *In debility, with acidity and flatulence.*

The writer finds this the best preparation to allay the craving of drunkards. Mr. Newman Hall, father of the present eminent preacher, ascribes his reformation from intemperance to steel as a tonic. The ammonio-chloride, anciently *Flores Martis*, is not in the P. B.

Citrate of Iron with Ammonia.

℞. Ferri ammonio-citratis (*Bullock*), ℥ss.; ammoniæ sesquicarbonatis ʒss.; tincturæ cardamomi compositæ, syrupi, singulorum f℥iij. Aquæ f℥vj. Misce. Dosis, pars sexta ter die. *In debility, with acidity and flatulence.*

Citrate of Iron for Children.

℞. Ferri citratis, gr. xij. (*Bullock*), syrupi aurantii, fluidrachmas duas; aquæ destillatæ f℥iij. Misce. Dosis, f℥ss. ter die.

13. *Chloride of Iron Mixtures.*

℞. Tincturæ ferri sesquichloridi f℥ij.; syrupi zinziberis ℥j.; spiritûs ætheris nitrici f℥ii.; aquæ f℥vij. Misce. Sumantur cochlearia duo magna bis die.

There is no reason why medicine should be made more nauseous than is necessary; and patients describe the taste of the new solution and tincture of perchloride of iron in the P. B. as disgusting. On the contrary, the old muriated tincture of iron has a delicious ethereal perfume, and is the medicine to choose when an energetic and speedy action is desired. In cases of erysipelas and pyæmia, in which it is given in very large doses, as f℥j. every three or four hours, it passes through the alimentary canal, and completely deodorizes its contents. *Bestucheff's nervous tincture*, in which oxyde of iron, hydrochloric acid, and alcohol are exposed to the sun's rays and produce a solution of chloride of iron, ether, and alcohol, is the true type of this preparation.

Acetate of Iron.

℞. Liquoris ferri acetatis (*Pharm. Dub.*) fluidrachmam; aquæ pimentæ fluiduncias sex. Sumat æger partem sextam ter die.

This is a mild and effective vegetable salt of iron, strongly recommended by Mr. Goddard of Christchurch.

14. *Steel and Acid Mixture.*

℞. Ferri sulphatis gr. xij.; acidi sulphurici diluti f℥j.; tincturæ cardamomi compositæ f℥ss.; infusi rosæ compositi f℥vss. Misce, sumantur cochlearia duo magna bis vel ter die.

15. *Steel, Ammonia, and Quassia.*

℞. Infusi quassiæ ℥ss.; tincturæ ferri ammoniati ℥ss.; ammoniæ sesquicarbonatis gr. vj.; syrupi aurantii ℥j.; aquæ destillatæ ℥vij. Misce, fiat haustus, bis vel ter quotidie sumendus. *For hysterical women* (*Brodie.*)

Phosphate of Iron (*Pharm. Brit*).

℞. Ferri phosphatis gr. iij.; sacchari lactis, gr. iij.; fiat pulvis ter die sumendus.

℞. Syrupi ferri phosphatis P. B. ℥ij. Sumatur cochleare parvum ter vel quater die.

The American and French pharmaceutists seem to be successful in their preparations and combinations of phosphate of iron. There is a syrup of *pyrophosphate of iron*, much recommended by Haynes Walton, and made by Cooper, of Oxford Street; *Parrish's compound syrup of phosphates* of iron and lime, sometimes called *chemical food*, is an acid solution containing in one fluid drachm 2½ gr. phosphate of lime, 1 gr. of phosphate of iron, with traces of phosphates of soda and potassa, and free hydrochloric and phosphoric acids. The *lactate of iron* has little solubility and little taste, and is often mixed with ferruginous chocolate, &c. Of the *hypophosphites* we know nothing.

16. *Sulphate of Iron for Children.*

℞. Ferri sulphatis gr. iij.; acidi sulphurici diluti ♏xij.; syrupi zinziberis ℥iij.; aquæ florum aurantii ℥iij.; aquæ destillatæ ℥ijss. Misce. Dosis, ℥ss. ter die.

17. *Syrup of Iodide of Iron* (*Pharm. Brit.*)

℞. Syrupi ferri iodidi ℥j.; sumat æger guttas xx.—xl., bis die, e cyatho aquæ, vel infusi zinziberis. (*Dr. A. T. Thompson.*)

Iodide of Iron, with Sarsaparilla.

℞. Syrupi ferri iodidi, syrupi sarsæ ää ℥ij. Misce. Sumat æger cochleare parvum bis quotidie ex aqua. (*Dr. Ferguson.*)

N.B. Blancard's pills of iodide of iron are a good form.

18. *Mistura Ferri Aromatica, or Heberden's Ink.*

℞. Corticis cinchonæ lancifoliæ contusi ℥j.; caryophyllorum contusorum ʒij.; ferri ramentorum ℥ss.; aquæ menthæ piperitæ ℥xv.; macera per dies tres in vase clauso, subinde agitando, dein cola, et adde tincturæ cardamomi compositæ ℥iij.; tincturæ aurantii ℥iij. Dosis, ℥j.—iij. bis vel ter die. *A most agreeable aromatic tonic. The Dublin Pharmacopœia, from which this formula is taken, orders ʒiij. of sliced calumba root with the bark: but the preparation is less nauseous without it.*

Iron with Quinine.

Amongst milder forms are the well-known "Citrate of iron and quinine" of Bullock. The following is convenient and energetic.

℞. Quinæ disulphatis ℈j.; tincturæ ferri muriatis fʒiiss.; syrupi aurantii fʒiv. aquæ fʒxiv. One teaspoonful and upwards for a dose, mixed with water. (*Parrish.*)

19. *Griffith's Mixture.*

℞. Myrrhæ contritæ ʒj.; potassæ carbonatis ʒss.; aquæ fʒvss.; ferri sulphatis gr. xij.; spiritus myristicæ fʒss.; sacchari ʒiv. First dissolve the sulphate in two ounces of water, and put it into the bottle; then rub the other ingredients smoothly together, and add them. Dose, fʒj.—jss. thrice daily. *The original prescription is to be seen in Dr. Moses Griffith's Practical Treatise on Hectic Fevers and Pulmonary Consumption, written at Colchester, 1776. New Ed. Lond.* 1795. *Dr. Griffith frequently varied the proportion of the ingredients, and sometimes added tincture of bark, nitre, &c.*

20. *Steel with Aloes.*

℞. Misturæ ferri compositæ, decocti aloes compositi partes equales. Dosis, fʒj. ter die. *In chlorosis, constipation with debility, &c.*

℞. Extracti aloes purificati gr. vj.; ferri sulphatis gr. xij.; extracti glycyrrhizæ gr. xij. Misce et divide in pilulas xij.; quarum sumatur una bis die, ante cibum.

21. *Nux Vomica and Strychnia.*

℞. Tincturæ nucis vomicæ (*Pharm. Brit.*) fʒj.; acidi nitromuriatici diluti fʒij.; tincturæ zinziberis fʒij.; syrupi fʒiij.; aquæ fʒvss.; Misce. Dosis, pars sexta ter die. *In any form of functional paralysis after all known causes are remedied. In obstinate debility, diabetes insipidus, alkaline urine, &c.*

Nux vomica is the pleasantest bitter possible, and may be given alone or combined with acids, other tonics, or purgatives. Torpidity of the nervous system is the condition in which it is assumed to be useful. The writer assumes gr. ½ of strychnia equal to ½ gr. of ext. nucis vomicæ.

℞. Extracti nucis vomicæ gr. ij.; mannæ ℈j. Misce et divide in pilulas viij.; quarum sumatur una ter die. *The extract, such as is prepared by Squire, is quite as efficacious a medicine as strychnia itself, and very much safer. Any mistake in dispensing strychnia might be fatal. The dose may be increased by degrees.*

If strychnine be preferred, use the Liquor Strychniæ *Pharm. Brit.*, of which ♏x. = gr. ½ of the alkaloid.

Phosphoric Acid and Strychnia.

℞. Acidi phosphorici diluti fʒiij.; tincturæ nucis vomicæ fʒij.; syrupi zinziberis fʒvij. Misce. Dose, one teaspoonful thrice a day in a

wine-glass of water. *There is an idea prevalent that phosphoric acid has some specific virtues in restoring the nervous system. This is absurd; but the acid is a good tonic notwithstanding. If digestion is feeble, a dessert-spoonful of pepsine wine may be taken with each dose.*

22. *Dilute Nitromuriatic Acid.*

℞. Acidi nitrici fortissimi ʒj.; acidi hydrochloriei fʒij. Misce et serva per horas xxiv. subinde agitans. Dein adde, aquæ destillatæ fʒxv. Dosis, ♏x.—xxx. ex aqua.*

℞. Acidi nitromuriatici diluti fʒij.; spiritus ætheris nitrici fʒij.; syrupi fʒss.; aquæ fʒvijss. Misce. Sumatur pars sexta ter die. *In dyspepsia, with nasty tongue and inactive liver.*

(*With a dose of this it is often useful to give a pill containing a grain of sulphate of zinc with a little bitter extract, and in other cases a drachm of liquor taraxaci.*)

℞. Acidi nitromuriatici diluti fʒij.; infusi chirettæ fʒvijss. Misce. fʒiss. ter die. *A bitter that is very grateful to irritable bowels.*

23. *Nitric Acid Mixture to relieve Thirst.*

℞. Potassæ nitratis ʒj.; acidi nitrici diluti fʒij.; syrupi fʒij.; aquæ puræ Oij.; Misce. Dosis, fʒiv. pro re natâ. *Mr. Cole.*

Dilute Nitromuriatic Acid with Orange Peel.

℞. Acidi nitrici diluti, acidi muriatici diluti ää fʒjss.; syrupi aurantii fʒj.; aquæ florum aurantii fʒj.; aquæ destillatæ fʒxiij. Misce; sumatur cyathus vinarius ter vel quater die. (*Brodie.*)

Hope's Nitrous-Acid Mixture for Dysentery and Diarrhœa.

℞. Aquæ camphoræ fʒiv.; acidi nitrosi ♏xxx.; tincturæ opii ♏xl. Misce. A table-spoonful every two hours. *Quoted by Parrish from* Ed. Med. and Surg. Journ., Jan. 1824. *Hope was a surgeon at Chatham. P. says that this has a wide reputation in the United States. It is interesting as evidence of the true traditional method of treating diarrhœa in hot weather by acids.*

24. *Sulphuric Acid Mixture.*

℞. Acidi sulphurici diluti fʒij.; syrupi aurantii fʒvj.; aquæ fʒvijss. Misce. Sumatur pars sexta ter die. *A grateful refrigerant and tonic in debility with profuse perspiration, in hot weather, &c.*

25. *Sulphuric Acid and Æther, or Sutton's Punch.*

℞. Acidi sulphurici diluti ♏xl.; spiritûs ætheris sulphurici compositi fʒij.; sacchari albi ʒss.; aquæ menthæ viridis fʒvj. Misce. Sumatur pars quarta, quater die. *An admirable restorative after illness; for delirium tremens, &c.*

* This is very nearly the strength of the dilute nitro-hydrochloric acid of the P. B.

26. *Stimulating Mixtures.*

℞. Spiritus ætheris chlorici f℥j.; pulveris acaciæ ℥j.; aquæ f℥iv. Misce. Dosis, pars quarta subinde.

℞. Ammoniæ sesquicarbonatis gr. xx.; spiritus ætheris sulphurici f℥j.; syrupi zinziberis f℥iij.; aquæ anethi f℥iijss. Misce. Dosis, pars quarta, subinde. *In syncope, hysteria, tympanites, &c.*

Chloroform Mixture with Camphor.

℞. Chloroformi f℥j; camphoræ gr. xxx.; ovi vitellum; aquæ f℥vj. Tere simul, ut fiat mistura. Dosis, f℥j.—(*United States Pharm.*)

Mistura quatuor Aromatum Vinosa, vulgo, Negus.

℞. Cinnamomi, zinziberis, myristicæ, caryophillorum singulorum contusorum ℈j.; sacchari albi ℥j.; vini *Claret* dicti f℥vj. (vel vini Hispanici, vel Lusitanici generosi, aquæ ferventis ää f℥vj.) Calefac simul in vase idoneo, super ignem, donec ebullitio incipisse videbitur, dein cola. Dosis, f℥ij. *In syncope, sinking, rigors, &c.*

White Wine Whey.

℞. Vini Xerici (vulgo *Sherry*), vel vini ex Insulis Fortunatis devecti (vulgo *Madeira*), cyathum vinarium; lactis recentis fervefacti octarium dimidium; coque simul donec caseum lactis coierit, dein cola per linteum.

Egg Wine.

℞. Ovi recentis vitellum; conquassa bene cum cochleari uno aquæ frigidæ. His infunde paulatim Vini Xerici cyathum, cum parte æquali aquæ mistum et fervefactum. Adjice myristicæ pauxillum.

A Nightcap.

Dissolve a quarter of an ounce of isinglass and two lumps of sugar in a small tumbler of boiling water. Add half a glass of brandy, or a glass of sherry, or two glasses of claret, and a bit of nutmeg or cinnamon. *A capital thing for a patient who is afraid of cholera.*

28. *Strong Camphor Mixture.*

℞. Camphoræ gr. xxv.; amygdalas dulces decorticatas sex; sacchari puriticati ℥iij.; optime contere dein adde gradatim, aquæ menthæ viridis f℥vijss.; ut fiat mistura, cujus sumantur cochlearia tria magna quartâ quâque horâ. (*Hooper.*) *In hysteric and various nervous and spasmodic affections.*

A modern *essence of camphor* (*not* spirit of camphor), freely miscible with water, is sold by most chemists.

29. *Indian Hemp.*

℞. Extracti cannabis Indicæ (*Squire*) gr. iij.; mannæ grana duodecim. Misce, et divide in pilulas duodecim. *Dose, one, two, or*

more. An uncertain, but very often efficacious narcotic in tetanus, neuralgia, and other painful maladies.

℞. Tincturæ cannabis Indicæ ℥x.; mucilaginis ʒij.; aquæ ʒjvj. Misce fiat haustus.

30. *Compound Soothing Pills.*

℞. Pulveris ipecacuanhæ compositi, extracti conii, singulorum ʒj; misce et divide in pilulas xxiv.; quarum sumantur una vel duæ subinde. *In painful ulcers, chronic rheumatism, stricture, &c.* (*C. Mayo.*)

℞. Extracti hyoscyami, extracti conii, extracti papaveris, singulorum ℈j. Misce et divide in pilulas xij. *In similar cases.*

31. *Pulvis Sudorificus Salinus.*

℞. Pulveris ipecacuanhæ compositi grana quindecim; potassæ nitratis grana quindecim; potassæ bicarbonatis grana quinque. Misce, fiat pulvis, horâ somni sumendus, e cyatho ptisanæ.*

32. *Compound Opiate Mixtures.*

℞. Liquoris opii sedativi ℥xx.; spiritus ammoniæ aromatici, spiritus ætheris nitrici, singulorum ʒiss.; syrupi ʒij.; misturæ camphoræ ʒvss. Misce. Dosis, pars quarta, quartis horis.

℞. Morphiæ hydrochloratis granum; acidi hydrochlorici diluti guttas duas; aquæ ʒviiss.; syrupi zinziberis ʒss. Misce. Dosis, pars octava.

℞. Syrupi papaveris ʒiv.; magnesiæ carbonatis ʒss.; spiritus ætheris nitrici; tincturæ hyoscyami, singulorum ʒij.; misturæ camphoræ ʒvij.; Misce. Dosis, pars sexta subinde. *To tranquillize the system after injuries, operations, accouchements, hæmorrhage, violent mental excitement, &c.* (*Dr. Gooch.*)

Mr. Cole's Stimulating Narcotic Draught for Delirium Tremens.

℞. Extracti opii (Hill) gr. ij. vel iij; aquæ ferventis ʒiv.; tere in mortario et adde *brandy* ʒiss.; sacchari q. s. Misce. *The patient should be allowed to sip this out of the tumbler, like a glass of grog.* Cole's Mil. Surg., p. 59.

* We offer this as a substitute for the original *Pulvis Doveri*, the recipe for which is as follows:—"Take opium an ounce, saltpetre and tartar vitriolated each four ounces, ipecacuanha one ounce, liquorice one ounce. Put the saltpetre and tartar into a red-hot mortar, stirring them with a spoon till they have done flaming: then powder them very fine; then slice in your opium, grind these to a powder, and mix the other powders with these. Dose from 40 to 50 or 70 grains in a glass of white wine posset, going to bed; covering up warm, and drinking a quart or three pints of the posset-drink while sweating." Dr. Dover accounts for the largeness of the dose by saying, that the properties of the opium are mitigated by the other ingredients; but in the present day, four, six, or seven grains of opium would be a dangerous dose, spite of the other ingredients. But if this is a true copy of the recipe, it is very difficult to understand how the saltpetre and vitriolated tartar can *flame* when heated together. Possibly the cream of tartar was used, and not the sulphate of potass.—See 'The Ancient Physician's Legacy to his Country,' by Thomas Dover, M.B. Fifth edition. 1733.

Chlorodyne.

This is a popular compound narcotic, said to be made of chloroform, muriate of morphia, oil of peppermint, Indian hemp, capsicum, sulphuric ether, perchloric acid, and prussic acid; combined with rectified spirit, syrup, and treacle. There is nothing new in the principle of combining several soothing medicines in one prescription, as our own formulæ, published for many years, amply testify; and any practitioner who desires to economize *opium*, should combine a lesser dose of it, with small doses of conium, henbane, camphor, Indian hemp, or some of them. Mr. Jolley, the eminent chemist, of Curzon Street, tells the writer that his predecessor made thirty years ago, and that he continues to sell, a compound called *Moody's Anodyne*, containing opium, syrup of poppies, the true old chloric ether (made by distilling alcohol and muriatic acid;—not the modern solution of chloroform), and some aromatics.

Dr. W. E. Bowman, Editor of the Canada Lancet, gives the following formula for chlorodyne in his Journal, Oct. 15th, 1864:—

"Take of Chloroform . . . . . half a fluid ounce.
Sulphuric Ether . . . . . ninety minims.
Oil of Peppermint . . . . . eight drops.
Resin of Indian Hemp . . . . . six grains.
Capsicum, bruised . . . . . two grains.
Mix and let them stand a few days, shaking occasionally.

"Take of Muriate of Morphine . . . . . sixteen grains.
Water . . . . . two drachms.
"Solve in a test tube with heat, and, when cold, add
Scheele's Hydrocyanic Acid . . . . sixty-four minims.
Perchloric Acid . . . . . one fluid drachm.
Thick Treacle . . . . . two fluid ounces.
Mix all together, and add little by little,
"Treacle or Water, or both, until enough has been put in to make up the quantity of chlorodyne to four fluid ounces.

"The treacle requires to be of the same specific gravity as the mixture of chloroform and ether. If too thick it will sink to the bottom of the bottle, and require the addition of a little water. But, if too thin, the treacle will float on the surface, and necessitate the addition of more ether to farther reduce the density of the chlorodyne.

"This chlorodyne dropped from the lip of an ordinary vial, gives 120 drops to the fluid drachm, and is readily miscible in prescriptions.

"Each dose of half a drachm contains 4 m. of chloroform, $1\frac{1}{2}$ m. of ether, $\frac{1}{10}$ gr. extract of hemp, $\frac{1}{4}$ gr. muriate of morphia, and 1 m. of Scheele's acid."

Remedies which persuade Sleep.

Orangeflower water is decidedly ranked by the French amongst the *calmants;* and half a wine-glassful will often coax a patient to sleep: so will valerian, musk, and castor; amongst wines the Burgundy; amongst beers Guinness's Dublin stout; last, not least, the tincture of sumbul in doses of two drachms, given in a little orangeflower water.

§ II. APERIENTS.

33. *Calomel.*

℞. Calomelanos, grana quinque; antimonii tartarizati grana ij; fiat pilula.

℞. Calomelanos grana quatuor; extracti colocynthidi compositi grana sex; fiant pilulæ duæ.

34. *Black Draught.*

℞. Sennæ foliorum ʒvj.; zinziberis concisi ʒss.; extracti glycyrrhizæ ʒij.; potassæ carbonatis ʒss.; aquæ ferventis fℨix. Post horas tres cola, et adde spiritûs ammoniæ aromatici fℨij.; magnesiæ sulphatis ℨj; (vel potassæ tartratis ℨj.) tincturæ sennæ, tincturæ cardamomi compositæ ää fℨss. Dosis fℨjss.*

Red Draught.

℞. Magnesiæ sulphatis ʒij.—iv.; syrupi zinziberis, tincturæ cardamomi compositæ, singulorum fʒj.; infusi rosæ compositi fʒx. Misce.

35. *Haustus Magnesiæ Sulphatis Acidus.*

℞. Magnesiæ sulphatis ʒj.—ʒiv.; syrupi aurantii fʒij.; acidi sulphurici diluti ♏x.; aquæ fℨj. Misce, fiat haustus. *To this draught may be added one grain of sulphate of zinc, or of sulphate of iron, or two grains of quinine, or fifteen minims of tincture of nux vomica, in cases of debility.*

36. *Haustus Magnesiæ Albus.*

℞. Magnesiæ sulphatis ʒij.; magnesiæ carbonatis ℈j.; syrupi zinziberis fʒjss.; aquæ menthæ viridis fʒxj. Misce, fiat haustus. *This draught will often be retained by the stomach when almost every other is rejected.*

37. *Cordial Aperient Draught.*

℞. Tincturæ sennæ fℨss.; tincturæ rhei fℨss. Misce.

38. *Rhubarb Draughts and Powders.*

℞. Pulveris rhei, semiscrupulum; sodæ bicarbonatis, scrupulum; sacchari albi, scrupulum; olei lavandulæ guttas quinque. Misce, fiat pulvis, e cochlearibus duobus aquæ sumendus. *This is the most perfect combination of rhubarb. The lavender hides its flavour completely.*

* This draught is greatly improved, both in flavour and efficacy, by the addition of a few carraway seeds and cloves, one ounce of buckthorn juice, one of tincture of jalap, and six of moist sugar.

℞. Pulveris rhei, bismuthi trisnitratis, confectionis aromaticæ, āā ℈ij.; aquæ menthæ piperitæ f℥iv. Misce. Sumatur pars quarta bis die. *In habitual constipation and flatulence.*

℞. Rhei gr. xv.; magnesiæ carbonatis ℈ss.; spiritus ammoniæ aromatici f℥ss.; syrupi f℥j.; aquæ anethi f℥x. Misce. *For cases of colic, diarrhœa, with acidity and indigestion, &c.*

Rhubarb and Polychrest Salt. (*Dr. William Fordyce.*)

℞. Pulveris rhei, potassæ sulphatis āā ℥j.; pulveris zinziberis ʒj. Misce. Dosis gr. x.—xl. *A capital aperient for children; serving, in most cases, all the purposes of calomel: much lauded in scrofula, especially if the upper lip be swelled.*

℞. Rhei, potassæ sulphatis āā ℈j.; spiritus lavandulæ compositi f℥j.; aquæ f℥j. Misce, fiat haustus. *A warm efficient purgative.*

39. *Saline Aperient Draughts.*

℞. Sodæ potassio-tartratis ʒiv.; succi limonum f℥ij.; syrupi zinziberis f℥j.; spiritûs myristicæ f℥ss.; aquæ f℥ij. Misce, fiat haustus. *A cooling purgative.*

℞. Sodæ potassio-tartratis ʒij. sodæ sesquicarbonatis ℈j.; sacchari albi ʒj.; fiat pulvis, e cyatho aquæ sumendus, cum cochleari magno succi limonis, vel cum acidi citrici granis quindecim.

40. *Epsom Salts and Tartar Emetic.*

℞. Magnesiæ sulphatis ℥j.; antimonii tartarizati gr. j.; aquæ menthæ f℥x. Misce; sumantur cochlearia magna tria, quartâ quâque horâ. *An active nauseating aperient, fit for robust persons threatened with acute inflammation.* (*Sir A. Cooper.*)

41. *Saline Aperients with Tonics.*

℞. Magnesiæ sulphatis ʒiv.; ferri sulphatis gr. viij.; quinæ disulphatis gr. xij. acidi sulphurici diluti f℥jss.; syrupi zinziberis f℥j.; tincturæ ejusdem f℥ij.; aquæ f℥viij. Misce. Dosis, pars octava bis die.

℞. Magnesiæ sulphatis ʒj.; acidi sulphurici diluti f℥j.; ferri sulphatis gr. xv.; infusi gentianæ compositæ f℥iij.; tincturæ aurantii f℥iv.; infusi rosæ f℥vj. Misce. Dosis pars sexta bis quotidie.

℞. Ferri potassio-tartratis ʒij.; sodæ potassio-tartratis ℥vj. Misce; fiant pulveres sex. Sumatur una mane, ex cyatho aquæ. *Combinations of saline purgatives with tonics, so as to answer the double purpose of draining congested abdominal veins, and bracing the system, are of great efficacy in most chronic complaints. The second of these formulæ is a prescription of Dr. Jephson's, who was famous for such combinations.*

42. *Pulvis e quatuor Salibus, or "German Powder."*

℞. Sodii chloridi, sodæ sulphatis, magnesiæ sulphatis, potassæ sulphatis, singulorum partes æquales. Optime misceantur, et desiccentur ante ignem. Dosis ʒj.—ij., ex cyatho aquæ calidæ. *An agreeable saline aperient. A grain of sulphate of iron or quinine may be added to each dose, with sugar or ginger, if agreeable. Some of the author's patients have named it German Powder from its resemblance to the water of chalybeate aperient springs.*

43. *Hospital House Physic.*

℞. Magnesiæ sulphatis ℥ij.; pulveris rhei, jalapæ ää ʒj.; aquæ menthæ piperitæ f℥vij. Misce. Dosis, pars sexta.

45. *Castor Oil Mixture.*

There is nothing offensive in the taste of castor oil, but it is indigestible and creates unpleasant eructations. People of sense take it floated in a little brandy, or in an acid effervescing draught. They who want it disguised may adopt the following draught, the proportions of which we copy from Parrish.

℞. Pulveris gummi acaciæ, sacchari albi, singulorum ʒiij.; olei menthæ piperitæ guttas quatuor; olei ricini f℥j. Rub the gum, sugar, and mint into a powder; add about ʒvj. of water, then the castor oil by degrees, with a little more gum *or* a little more water as may be necessary to make a perfect emulsion. Then add water slowly to bring the quantity to ʒiv. Dose ℥ss.—℥j.

Castor Oil and Turpentine Mixture.

Substitute half an ounce of oil of turpentine, for half of the castor oil in the above.

46. *Aperient Electuaries.*

℞. Pulveris potassæ supertartratis ℥ss.; sulphuris precipitati ʒij.—iv.; confectionis sennæ ℥j.; syrupi zinziberis, quantum satis s.t.

℞. Magnesiæ ustæ, potassæ supertartratis, pulveris rhei, ää ʒj.; pulveris zinziberis ʒss.; theriacæ, quantum satis est.

℞. Mannæ, confectionis sennæ, ää ʒj.; sulphuris ʒiij.; syrupi quantum satis sit. Dosis ʒj.—iv., omni nocte horâ somni. *For piles, &c.*

47. *Pilulæ Catharticæ.*

℞. Aloes ℥ss.; pulveris colocynthidis, cambogiæ ää ʒj.; jalapæ ʒij.; saponis ʒj.; antimonii tartarizati ℈ss.; olei caryophillorum ♏xx.; contunde simul, et divide in pilulas, pondere granorum quinque. *A thorough but easy purge.*

48. *Pilulæ Cathartice cum Calomelane.*

℞. Pilulæ præcedentis ʒiv.; calomelanos ʒj. Misce et divide in pilulas lx.

Pilulæ Hyperca harticæ.

℞. Extracti colocynthidis compositi ℈ij.; olei crotonis guttas duas. —Divide in pilulas octo, quarum sumantur duæ. *For threatened apoplexy, œdema, glottidis, &c.*

Podophyllin,

As prepared by Hudson of the Haymarket, is a most efficient drastic purge applicable to cases of convulsions of children, &c. One grain is a large dose. But it is difficult to detect any superiority in podophyllin over good scammony.

49. *Blue Pill and Colocynth.*

℞. Pilulæ hydrargyri ℈ss.; extracti colocynthidis compositi ℈ijss. Misce, fiant pilulæ duodecim.

50. *Sulphate of Iron with Aloes.*

℞. Ferri sulphatis, aloes Barbadensis, āā ʒij.; pulveris rhei ʒj. Misce, et divide in pilulas lx. Dosis, una vel duæ horâ somni. *An admirable aperient for weak constipated persons.*

51. *Pilulæ Aloes Dilutæ.*

℞. Extracti aquosi aloes Barbadensis, saponis, theriacæ, extracti glycyrrhizæ āā ʒj. Solve leni calore in balneo; dein divide in pilulas xlvij. Dosis, una horâ somni. *A capital eccoprotic aperient, unloading the colon of scybala, but rather irritating to the rectum. The aloes should be of the best Barbadoes kind, purified by solution in water. The formula is attributed to Dr. Marshall Hall.*

52. *Ipecacuanha and Rhubarb Pills.*

℞. Pulveris ipecacuanhæ gr. xxiv.; pulveris rhei ℈iv.; saponis ℈ss. Misce et divide in pilulas xxiv.; quarum sumatur una ter die. *A gentle aperient in piles and other congested conditions of the intestines.*

℞. Ipecacuanhæ gr. vj.; extracti aloes purificati gr. vj.; extracti rhei gr. xxxvj.: olei cajuputi ♏iv. Misce et divide in pilulas xij.; sumatur una, horâ ante prandium. *A good dinner pill for constipated persons.*

Rhubarb and Ginger Pills.

℞. Rhei ʒj.; tincturæ zinziberis fortissimæ q. s., ut fiat massa in pilulas xij., dividenda.

53. *Pills of Aloes and Sulphuric Acid.*

℞. Aloes Barbadensis gr. xxiv.; acidi sulphurici fortissimi guttas vj. Misce et divide in pilulas vj.; quarum sumantur duo, quartâ quâque horâ. *A very powerful aperient that often succeeds when almost everything else fails. The author is indebted for the prescription to his friend Dr. Dickson.*

54. *Guaiacum and Jalap Pills.*

℞. Guaiaci pulveris, extracti jalapæ, extracti hyoscyami, āā ℈j.; cambogiæ gr. iij. Misce et divide in pilulas duodecim; quarum sumantur una vel duæ horâ somni. *An active purge, not irritating to the rectum.* (*The late T. A. Stone.*)

55. *Gingerbread Electuary.*

℞. Guaiaci pulveris ʒij.; sulphuris, rhei, āā ʒj.; zinziberis ʒj. *Treacle* quantum satis sit ut fiat electuarium. Dosis, pars sexta. (*Said to be Sir C. Locock's.*)

56. *Guaiacum Electuaries.*

℞. Pulveris guaiaci gr. v.; pulveris chinchonæ ℈j.; pulveris cinnamomi compositi ℈ss. Misce, fiat pulvis bis die sumendus.

℞. Pulveris guaiaci ʒij.; pulveris rhei ʒss.; sulphuris ʒj.; pulveris myristicæ ʒss.; theriacæ quantum satis est ut fiat electuarium. Dosis, pars sexta omni nocte. *In chronic rheumatic diseases. This is commonly called the Chelsea Pensioner.*

57. *Sulphate of Manganese.*

℞. Manganesii sulphatis ℈j.; magnesiæ sulphatis ʒij.; syrupi zinziberis ℥j.; aquæ ℥jss. Misce fiat haustus mane sumendus. *In gouty cases, to produce a copious discharge of bile.*

℞. Manganesii sulphatis, pulveris rhei āā ℈j.; spiritus lavandulæ compositi ℥j.; aquæ ℥jss. Misce fiat haustus. *Preparations of manganese are very likely to excite vomiting.*

§ III. Alterative and Febrifuge Medicines.

58. *Saline Draughts.*

℞. Potassæ nitratis ℈ij.; sodæ sesquicarbonatis ℈j.; syrupi croci, spiritûs ætheris nitrici āa ℥j.; aquæ ℥v. Misce. Dosis ℥jss. quartâ quâque horâ.

℞. Potassæ nitratis gr. x.; sacchari ℈j. Misce fiat pulvis, sumendus e cyatho vinario aquæ menthæ viridis. *Green mint water and nitre form a very agreeable mixture, and produce a pungent cooling sensation on the tongue and palate. But the salt should only be dis-*

solved at the moment of administration, and the mint water should be quite cool. Attention to these trifles makes a great difference to a patient who is parched with fever.

Effervescing with Potass.

℞. Potassæ bicarbonatis ℈iv.; syrupi zinziberis f℥ij.; aquæ f℥vss. Dosis f℥jss. quartâ quâque horâ, cum f℥ss. succi limonum recentis.

Effervescing with Ammoniæ.

℞. Ammoniæ sesquicarbonatis ℈ijss.; tincturæ cardamomi compositæ f℥ss.; aquæ f℥v. Misce. Dosis f℥jss. quartâ quâque horâ, cum cochleari magno succi limonum, vel gr. xv. acidi citrici. *In the early stage of erysipelas, and low fevers.*

Mindererus Draught.

℞. Liquoris ammoniæ acetatis f℥ij.; spiritûs ætheris nitrici f℥ss.; misturæ camphoræ fluiduncias quinque cum semisse. Misce. Dosis, pars quarta, quartâ quâque horâ.

Carbonate of Ammonia.

℞. Ammoniæ sesquicarbonatis ℥ss.; spiritûs ætheris nitrici f℥iij.; misturæ acaciæ f℥iij.; misturæ camphoræ f℥vij. Misce. Dosis f℥iss. tertia vel quartâ quâque horâ.

59. *Digitalis Draught.*

℞. Tinct. digitalis ♏iv.; aceti destillati f℥j.; syrupi f℥j.; aquæ f℥jss. Misce; fiat haustus ter die sumendus, ad duodecim vices.

60. *Boracic.*

℞. Sodæ biboratis ℥j.; sodæ sesquicarbonatis ℥ss.; potassæ nitratis ℥ss. Misce et divide in pulveres sex; quorum sumatur unus ter die e cyatho aquæ. *In lithic deposits.*

61. *Phosphate of Soda.*

℞. Sodæ phosphatis ℥iij. Fiat pulvis, mane sumendus e cyatho aquæ. *As an aperient when the urine is red.*

℞. Sodæ phosphatis ℈j.; infusi gentianæ compositi f℥j. Misce, fiat haustus bis die sumendus.

62. *Calomel and Opium Pill.*

℞. Calomelanos gr. j.—ij.; pulveris opii gr. ¼—½; extracti glycyrrhizæ quantum sufficit ut fiat pilula, quartis—sextis horis sumenda. *To mercurialize the system in acute inflammation.*

Calomel and Opium with Antimony.

℞. Calomelanos gr. j.—ij.; pulveris opii gr. ¼—½; antimonii tartarizati gr. ¼; extracti glycyrrhizæ quantum satis sit ut fiat pilula. *This formula may be used when there is a considerable amount of sthenic inflammation.*

63. *Alterative Pill.*

℞. Pilulæ hydrargyri, granum dimidium; extracti hyoscyami gr. ij. Misce, fiant pilula bis vel ter die sumenda.

64. *Alterative Powders.*

℞. Hydrargyri cum creta gr. iij.—vj.: pulveris Doveri gr. j.—v. Sodæ sesquicarbonatis, sacchari albi ää ℈j. Misce, fiat pulvis omni nocte sumendus.

℞. Hydrargyri cum creta gr. ij.; pulveris rhei gr. v.; sacchari ℈ss.; pulveris cinnamomi gr. v. Misce, fiat pulvis, omni nocte sumendus. *As a gentle alterative in chronic diseases, when the secretion of bile and urine is scanty.*

65. *Calomel and Colchicum.*

℞. Calomelanos gr. iv.; extracti colchici acetici gr. xij.; extracti colocynthidis compositi gr. xxiv.; extracti hyoscyami gr. xxiv. Misce, fiant pilulæ duodecim, quarum sumat unam vel duas horâ somni. *In rheumatic and gouty inflammations.*

66. *Plummer's Pill.*

℞. Sulphurati aurati antimonii, calomel ää ʒij.; tere simul donec bene misceantur, dein adde pulveris resinæ guaiaci ʒiv.;* balsami copaibæ q. s. ut fiat massa pilularis ex cujus singulis drachmis formentur pilulæ xij. *Abridged from Dr. Andrew Plummer's original paper in the "Medical Essays and Observations published by a Society in Edinburgh," vol. i., 1747. Dr. Plummer was Professor of Medicine in the University of Edinburgh at that time.*

67. *Tartar Emetic with Mercury.*

℞. Antimonii potassio-tartratis gr. j.; hydrargyri cum creta gr. viij.; extracti conii gr. xvj. Misce et divide in pilulas octo; quarum sumatur una bis vel ter die.

68. *Tartar Emetic.*

℞. Antimonii tartarizati, granum; aquæ destillatæ, fluidunciam. Sumatur cochleare parvum quarta quâquâ horâ.

℞. Antimonii potassio-tartratis gr. j.—ij.; syrupi papaveris ℥ss. aquæ destillatæ ℥vijss. Misce; sumantur cochlearia duo magna ter die.†

* In the original, gummi guaiaci ʒiij.; resinæ guaiaci ʒj.

† The inventor of the contrastimulant method of administering tartar emetic was Thomas Marryat, born 1730, died 1792; practised at Bristol; a very eccentric person: author of "Therapeutics, or the Art of Healing," a work which passed through many editions, and was very popular with apothecaries at the beginning of the present century. The twenty-fourth edition was published in

℞. Antimonii potassio-tartratis gr. iij.; tincturæ opii ℥ss.; aquæ ℥vj. Misce. Dosis, cochleare unum omni semihorâ, vel majori intervallo donec delirium cessaverit. *In certain cases of delirium tremens and fever in which depletion is inadmissible, and excitement great, and strength sufficient. See Dr. Graves's Clinical Medicine.*

69. *Colchicum Draughts.*

℞. Vini radicis colchici ℥ss.; syrupi ℥ss.; aquæ ℥j. Misce, fiat haustus quartis—sextis horis sumendus.

70. *Colchicum and Magnesia,*

℞. Vini colchici ℥ij.; solutionis magnesiæ* ℥iss.; misturæ camphoræ ℥ivss. Misce; sumantur cochlearia duo quartâ quâque horâ.

℞. Magnesiæ carbonatis, sodæ sesquicarbonatis ää ℈ss.; vini seminum colchici ♏xv.; aquæ pimentæ ℥jss. Misce, fiat haustus ter die sumendus.

71. *White Purgative Draught with Colchicum.*

℞. Aceti colchici ℥j.; magnesiæ sulphatis ʒij.; magnesiæ carbonatis ℈j.; syrupi zinziberis ℥j.; aquæ anethi ℥x. Misce. (*Sir C. Scudamore.*)

72. *Antilithic Pill.*

℞. Extracti colchici acetici, hydrargyri cum creta ää gr. j.; extracti colocynthidis compositi gr. ij. Misce fiat pilula omni nocte sumenda.

Sir A. Cooper's Prescription for Chronic Gout and Rheumatism.

℞. Potassæ bicarbonatis ʒss.; tincturæ aurantii ℥ij.; decocti aloes compositi ℥viij. Misce; sumatur cyathus vinarius omni mane.

1816 by Sherwood. The author says, page 5, "Any fever may soon be extinguished by the use of the following powders:—Take of tartarized antimony five grains; white sugar or nitre a drachm. Let them be well rubbed in a glass mortar, and be divided into six powders; one to be taken every three hours, notwithstanding the nausea the first may probably occasion. If they bring on a diarrhœa they should still be continued, and it will soon cease. If these are taken (which is most commonly the case) without any manifest inconvenience, let there be seven grains in the next six powders, and in the next, ten. Here I beg leave to retract what I said in some former editions of this work: viz., that till sickness and vomiting was excited, this noble medicine was not to be depended on. For I have seen many instances wherein a paper has been given every three hours (of which there have been ten grains in six powders), without the least sensible operation, either by sickness, stool, urine, or sweat, and though the patients had been unremittingly delirious for more than a week with subsultus tendinum, and all the other appearances of hastening death, they have perfectly recovered without any other medical aid, a clyster every other day excepted."

* Made by Murray or Dinneford.

73. *Colchicum and Rhubarb.*

℞. Infusi rhei ℥ix.; vini colchici ♏xx.; potassæ bicarbonatis ℈j.; tincturæ cardamomi compositæ ℥j. Misce, fiat haustus horâ somni sumendus. *Dr. Marshall Hall.*

74. *Turpentine in small Alterative Doses.*

℞. Mucilaginis ℥ss.; sodæ sesquicarbonatis ℈ss.; olei terebinthinæ ♏xv.—xl.; aquæ destillatæ ℥i. Misce, fiat haustus. *In rheumatism, rheumatic ophthalmia, iritis, passive hæmorrhage, &c. See P. 45.*

75. *Lead Draught.*

℞. Plumbi acetatis gr. iij. aceti destillati ℥ij.; tinct. opii ♏j.—x.; syrupi rhœados ℥j.; aquæ destillatæ ℥vij. Misce; fiat haustus quartâ quâque horâ sumendus, ad sex vices. *In active hæmorrhage.*

76. *Tonic Aperient and Antacid Powders.*

℞. Sodæ carbonatis exsiccatæ gr. v.; pulveris calumbæ gr. x.; pulveris rhei, zinziberis ää gr. ij. Misce; fiat pulvis, quotidie ante prandium sumendus.

℞. Ferri sesquioxydi ℈j.; sodæ bicarbonatis gr. iij.; pulveris rhei gr. iij. Misce, fiat pulvis, ter die sumendus.

℞. Pulveris chinchonæ ℈j.; sodæ bicarbonatis gr. iij.; pulveris aromatici gr. v. Misce, fiat pulvis, ter die sumendus.

77. *Antacid and Carminative Mixtures.*

℞. Magnesiæ carbonatis ℈j.; spiritûs ammoniæ aromatici ℥ss.; syrupi aurantii ℥iij; aquæ calcis, aquæ destillatæ ää ad ℥iij. Misce, sumantur cochlearia duo magna ter die. *After meals.*

℞. Cretæ preparatæ ʒss.; liquoris calcis ℥iij.; aquæ anethi ad ℥ij. Misce, sumantur cochlearia duo magna ter die.

℞. Potassæ bicarbonatis ℈j.; infusi rhei ℥ij.; syrupi zinziberis ℥ij.; aquæ menthæ piperitæ ad ℥ij. Misce. Dosis ℥j. bis die.

The above prescriptions are intended for children with torpid appetites, red tongues, thirst, and loaded urine.

℞. Infusi caryophylorum ℥vijss.; sodæ bicarbonatis ʒj.; spiritûs ammoniæ aromatici ℥ij.; tincturæ cardamomi compositæ ℥ss. Misce. Dosis ℥jss. bis die.

℞. Ammoniæ sesquicarbonatis, potassæ bicarbonatis ää ʒss.; aquæ destillatæ ad ℥vijss. Dosis ℥jss. bis die. *For adults labouring under dyspepsia, acidity, and turbid urine. To be taken after breakfast and at bed-time.*

78. *Liquor Potassæ Mixtures.*

℞. Liquoris potassæ ℥iij.; syrupi ℥iij.; aquæ destillatæ ad ℥vij. Misce. Sumatur pars sexta ter die, post cibum.

℞. Liquoris potassæ; tincturæ gentianæ; syrupi zinziberis, spiritus ætheris nitrici ãã f℥iij.; aquæ destillatæ f℥vjss. Misce; sumatur pars sexta bis vel ter die, post cibum.

79. *Bismuth.*

℞. Bismuthi trisnitratis, drachmam; pulveris acaciæ ʒij.; potassæ bicarbonatis ʒj.; misturæ camphoræ fluiduncias sex. Misce. Dosis f℥jss. bis die. *To be taken an hour after breakfast and dinner in cases of gastrodynia and pyrosis. To this mixture ten minims of Scheele's prussic acid may be added if there is much pain.*

℞. Bismuthi trisnitratis ʒi.; magnesiæ carbonatis ʒss.; pulveris acaciæ ʒij.; aquæ f℥vj. Misce. Dosis f℥jss. bis die.

Pulvis Bismuthi Compositus.

℞. Bismuthi trisnitratis, pulveris acaciæ, sodæ bicarbonatis, singulorum ℈j.; pulveris zinziberis gr. v. Misce, fiat pulvis hora post cibum sumendus, ter die. *In all cases of irritable or chronic inflammation, attended with acidity, flatulence, and irritable stomach, these combinations of bismuth and alkali are most valuable.*

80. *Prussic Acid Mixtures*

℞. Acidi hydrocyanici diluti (*Pharm. Lond.*) ♏iv.; potassæ bicarbonatis gr. x.; syrupi zinziberis f℥ss.; aquæ anethi f℥jss. Misce, fiat haustus bis die sumendus. *In cases of irritable acid stomach.*

℞. Acidi hydrocyanici diluti (*Pharm. Lond.*) ♏iv.; misturæ cretæ f℥jss.; sodæ bicarbonatis gr. v. Misce, fiat haustus. *In the same class of cases, with irritable bowels.*

81. *Antilithic Powder.*

℞. Magnesiæ gr. vj.; potassæ bicarbonatis gr. xij.; potassæ tartratis gr. xv. Misce; fiat pulvis, omni vespere sumendus e cyatho parvo aquæ. (*Brodie.*)

82. *Sarsaparilla and Nitric Acid.*

℞. Decocti sarsæ compositi f℥iv.; acidi nitrici diluti ♏xx.—x.; tincturæ hyoscyami f℥ss. Misce, fiat haustus ter die sumendus.

83. *Alkaline Infusion of Sarsaparilla.*

℞. Sarsaparillæ Jamaicensis radicis, concisæ et contusæ ℥ij.; radicis glycyrrhizæ concisæ ʒij.; liquoris potassæ ♏xl.—lx.; aquæ destillatæ ferventis f℥x.; tincturæ cardamomi compositæ f℥iij. Macera per horas viginti quatuor, et cola. Sumatur totum quotidie. (*Brodie.*)

Sarsaparilla with Iodide of Potassium.

℞. Potassii iodidi gr. xl.; extracti sarsæ liquidi f℥ij.; solve. Dosis ʒij. bis die, ex aquæ.

84. *Sarsaparilla and Lime Water.*

℞. Sarsaparillæ ℥ij.; glycyrrhizæ ʒij.; liquoris calcis f℥x. Macera per horas viginti quatuor, et cola. Sumatur totum indies.

85. *Sarsaparilla Soup.*

To three ounces of sarsaparilla, sliced, add three pints of water; let them simmer on a slow fire until reduced to two pints; take out the root, bruise it, and return it into the water with half a chicken, or half a pound of beef without fat; boil them for an hour slowly, and pour off the soup for use.—*Dr. Colles's Lectures*, vol. ii. p. 346.

86. *Corrosive Sublimate Pills.*

R. Hydrargyri sublimati corrosivi, ammoniæ hydrochloratis ää gr. j.—ij.; aquæ destillatæ guttam; micæ panis quantum satis est, ut fiant pilulæ xij., quarum sumatur una ter die. *Sir B. Brodie.*

87. *Corrosive Sublimate and Bark for Children.*

℞. Hydrargyri sublimati corrosivi gr. j.; tincturæ cinchonæ (vel tincturæ rhei) ℥ij.; solve. Dosis f℥j. ter die ex aqua. *To be taken after meals.* (*Sir A. Cooper.*)

Corrosive Sublimate and Steel.

R. Hydrargyri sublimati corrosivi grana duo; tincturæ ferri sesquichloridi fluidunciam. Solve. Dosis, mimina quindecim ter die, e cyatho aquæ vel decocti hordei, vel sarsæ, vel cerevisiæ, vel *sweetwort.*

Iodides of Iron, Potassium, and Mercury.

℞. Potassii iodidi grana quadraginta; hydrargyri corrosivi sublimati granum unum; syrupi ferri iodidi fluidrachmas quatuor, syrupi aurantii fluidrachmas sex; aquæ fluiduncias sex—Dosis pars vigesima, ter die, e cyathao aquæ.

88. *Iodine Mixture.**

℞. Iodinii gr. ½; potassii iodidi gr. j.; aquæ destillatæ f℥vj.

Vel ℞. Tincturæ iodinii compositi (P. L.) ♏xx.; aquæ destillatæ f℥vj.

Vel R. Liquoris potassii iodidi compositi (P. L.) f℥ss.; aquæ destillatæ f℥vss. Misce. Sumatur totum indies diviſis dosibus.

89. *Iodine Ointment.*

℞. Iodinii gr. vij.; potassii iodidi ℈ij. adipis ℥j. Misce.

* These three formulæ are of the same strength. The dose of iodine may be gradually increased to gr. 4-5ths, or gr. i. daily.

Iodine Paint

Is composed of iodine with half its weight of iodide of potassium rubbed together with enough spirits of wine to make it of the consistence of paint. *Used as a strong discutient for bubo, diseased joints, &c.*

90. *Iodine Lotion.*

℞. Liquoris potassii iodidi compositi f℥j. ; aquæ destillatæ f℥x. Misce. *For Scrofulous Ulcers, Fistulæ, Ophthalmia, &c.*

91. *Rubefacient Solution of Iodine.*

℞. Iodinii, ʒiv. ; potassii iodidi ℈j. ; aquæ destillatæ f℥vj. Misce. *To touch very indolent sores, the edges of the eyelids, ozæna, &c.*

92. *Caustic Solution of Iodine.*

℞. Iodinii, potassii iodidi, āā ℈j. ; aquæ destillatæ f℥ij. Misce. *To destroy weak granulations, ragged edges of sores, &c.*

93. *Iodine Bath*

Should contain, for children, half a grain of iodine to each quart of warm water ; and, for adults, one drachm to twenty-five gallons. The body may be immersed ten minutes.*

94. *Iodide of Potassium with Bitters.*

℞. Potassii iodidi gr. xij. ; extracti gentianæ ℈ij. Misce et divide in pilulas duodecim.

℞. Potassii iodidi ℈j. ; infusi gentianæ compositi (*vel* decocti cinchonæ) f℥vss. ; tincturæ aurantii f℥ij. Misce. Dosis, pars sexta ter die.

95. *Iodide of Potassium with Alkali.*

℞. Potassii iodidi gr. xij. ; potassæ bicarbonatis ʒj. ; (*vel* liquoris potassæ f℥ij. ;) syrupi f℥ss. ; aquæ f℥vss. Misce. Dosis f℥j. bis die.

96. *Iodide of Potassium with Colchicum.*

℞. Potassii iodidi ℈j. : potassæ bicarbonatis ʒj. ; vini colchici f℥jss. ; syrupi f℥ij. ; misturæ camphoræ f℥viiss. Misce. Dosis, pars sexta, ter vel quater die.

97. *Arsenical Mixtures.*

℞. Liquoris arsenici chloridi f℥j. ; aquæ destillatæ f℥vj. Dosis, pars sexta ter die, post cibum. *This solution of arsenic was devised by Dr. De Valingen, an eminent physician who lived in Bishopsgate Street, at the beginning of the present century.*

The writer has had ample opportunities of verifying Mr. Hunt's

* Vide Essays on the Effects of Iodine in Scrofulous Diseases, by Lugol, translated by O'Shaughnessy. London, 1831.

opinion, that it is more safe and efficacious than the Liquor potassæ arsenitis, or Fowler's solution.

℞. Liquoris potassæ arsenitis ♏xx.—xxx. ; syrupi ʒiij. ; tincturæ cardamomi ʒij. ; aquæ destillatæ ƒʒvss. Misce. Dosis ƒʒj. ter die, statim post cibum.*

§ IV. Emetics.

98. *Relaxing Emetics.*

℞. Antimonii tartarizati gr. iij. ; aquæ destillatæ ƒʒiij. Misce, sumatur cochleare magnum frequenter, donec vomitus supervenerit.

℞. Antimonii tartarizati gr. j. ; ipecacuanhæ ℈j. Misce, fiat pulvis.

99. *Warm Emetics.*

℞. Pulveris ipecacuanhæ, ammoniæ sesquicarbonatis ää ℈j. ; spiritûs lavandulæ compositi ♏x. ; aquæ ƒʒj. Misce, fiat haustus. Bibat æger postea infusi anthemidis tepidi octarium. *In the incipient stage of Erysipelas, Fever, &c.*

℞. Farinæ sinapeos vulgaris cochleare magnum ; salis vulgaris cochleare ; aquæ tepidæ octarium. Misce.

100. *Zinc Emetic.*

℞. Zinci sulphatis ℈ij. ; aquæ ƒʒij. Misce, fiat haustus.

§ V. Enemata.

101. *Opiate Enema.*

℞. Decocti amyli ƒʒiv. ; tincturæ opii ƒʒss.—ʒj. Misce. (*Pharm. Lond.*)

Opiate Suppository.

℞. Pulveris opii gr. j.—iv. ; cetacei (vel sevi, i. e. *tallow*) gr. xx. ; misce.

* Mr. Hunt, who has had probably greater experience in the use of arsenic than any other man living, gives the following rules for its administration. "It should never be given when there is any feverishness ; never on an empty stomach ; never in increasing doses, the largest dose ever required being ♏x. of Fowler's solution three times a day. The first effect to be looked for is an itching or smarting of the conjunctiva, and swelling and puffiness of the lower eyelid ; upon which the dose should be reduced to three minims. If the conjunctiva continues much inflamed, the dose should be again reduced ; but it should be kept in a tender state throughout the course. The arsenical course should be continued for as many months after the disappearance of the skin disease, as it had existed years before." See Papers by Mr. Hunt, in Lancet for 1846, and his Treatise on Diseases of the Skin, Lond. 1847.

102. *Turpentine Enema.*

℞. Olei terebinthinæ f℥j.; vitelli ovi (*vel* mucilaginis acaciæ) quantum satis sit; tere simul et adde, decocti hordei, *vel* decocti avenæ, f℥xix.

103. *Tobacco Enema.*

℞. Tabaci foliorum ʒss.; aquæ octarium dimidium; macera per horæ quartam partem, et cola.

104. *Castor Oil Enema.*

℞. Olei ricini f℥iij.; potassæ carbonatis gr. xv.; saponis ʒj.; aquæ ferventis octarium; tere simul donec bene misceantur.

105. *Purgative Enemata.*

℞. Magnesiæ sulphatis ℥ij.; decocti avenæ octarium. Misce.

℞. Salis vulgaris ℥j.; decocti anthemidis octarium. Misce.

℞. Fellis bovini inspissati ℥ss.; saponis ʒj.; aquæ ferventis octarium. *Good for dissolving scybala.*

℞. Extracti colocynthidis ʒj.; aquæ ferventis octarium.

106. *Enemata for destroying Ascarides.*

℞. Aloes, saponis āā ℈j.; aquæ octarium.

℞. Aloes, saponis, assafœtidæ āā ℈j.; aquæ octarium. Misce.

℞. Infusi quassiæ octarium; ferri sulphatis gr. v. Misce.

N.B. The *dilute citrine ointment* (one part of the ointment to 12 of hard fat) is a capital remedy. A small piece should be put within the sphincter.

§ VI. Gargles.

107. *Detergent Gargle.*

℞. Liquoris sodæ chlorinatæ f℥iv.; mellis ℥j.; aquæ destillatæ f℥iij. Misce. *A tablespoonful to be mixed with a glass of warm brandy and water, to be used as a gargle.*

108. *Cooling and Sialagogue Gargles.*

℞. Mellis, confectionis rosæ caninæ āā ʒij.; aceti destillati f℥ss.; acidi hydrochlorici ♏xxx.; aquæ rosæ f℥j.; aquæ puræ f℥vj. Misce.

℞. Potassæ nitratis ʒj.; infusi rosæ compositi f℥viij. Misce.

℞. Oxymellis f℥iij.; misturæ camphoræ f℥v. Misce.

℞. Boracis ʒj.; mellis ℥j. aquæ rosæ f℥j.; aquæ f℥vj. Misce.

109. *Astringent Gargles.*

℞. Aluminis ʒj.; acidi sulphurici diluti ♏xx.; tincturæ myrrhæ f℥ij.; decocti cinchonæ f℥vj. Misce.

℞. Zinci sulphatis ʒss. ; aquæ f℥viij. Misce.

℞. Liquoris chloridi zinci (*Sir W. Burnett's Disinfecting Solution*) f℥ss. ; aquæ f℥viij. Misce. *An admirable wash for the mouth when the membrane is flabby and the secretion offensive.*

110. *Stimulating Gargles.*

℞. Tincturæ capsici f℥ij. ; oxymellis f℥ss. ; aquæ f℥vij-ss. Misce.

℞. Tincturæ pyrethri (F. 183) f℥ij. ; aquæ ℥viij. Misce.

111. *Tannin Gargle.*

℞. *Tannin* ℈j. ; *brandy* f℥ss. ; misturæ camphoræ f℥vss. Misce. *For salivation, spongy gums, relaxed throat, &c.*

112. *Corrosive Sublimate Gargle.*

℞. Hydrargyri sublimati corrosivi gr. ij. ; acidi hydrochlorici ♏xx. ; mellis ℥j. ; aquæ destillatæ f℥vij. Misce.

113. *Creosote Gargle.*

℞. Creosoti guttas xx. ; aquæ f℥viij. Agita simul donec solvetur creosoton.

Soothing Gargle.

℞. Extracti papaveris, drachmam ; boracis, drachmam ; aquæ fluiduncias octo. Misce.

Glycerine is a capital soothing application, in diphtheria, &c., either painted on with a camel's-hair pencil, or in combination with either of the above gargles. (See p. 838.)

§ VII. Lotions, Injections, and Collyria.

114. *Frigorific Mixture.*

℞. Sodii chloridi, potassæ nitratis, ammoniæ hydrochloratis, partes æquales ; aquæ quantum satis sit ad solvendum. *To be put into a bladder.*

115. *Spirit Lotion.*

℞. Spiritûs vini rectificati f℥j. ; aquæ f℥xv. Misce.

116. *Goulard's Lotion.*

"This is made by putting two teaspoonfuls, or 200 drops of the extract of Saturn (*Liq. Plumbi Diacetatis*), to a quart of water, and four teaspoonfuls of brandy." From a Treatise on the effects of Lead, &c.; from the French of Mr. Goulard, Surgeon-major to the Royal and Military Hospital of Montpellier, Lond. 1775. Dilute spirit of wine may be substituted for the brandy.

Nitrate of Lead.

℞. Plumbi nitratis, drachmam; aquæ destillatæ, octarium. Fiat lotio. *A capital deodorizing lotion for ulcers, cancers, &c.* (Dr. Ogier Ward.)

117. *Zinc Lotions.*

℞. Zinci sulphatis grana xx.; aquæ octarium. Misce.

Acetate of Zinc Lotion.

℞. Liquoris plumbi diacetatis f℥ss.; zinci sulphatis ʒss.; aquæ destillatæ, octarium dimidium.

Acetate of Zinc with Creosote Lotion.

℞. Plumbi acetatis, zinci sulphatis ää ℈ss.: creosoti guttam unam. Tere simul ut fiat pulvis, in aquæ octario dimidio solvendus ut fiat lotio. *The author learned this formula from Mr. Harvey. It may be supplied to patients in the form of powder, and is an excellent astringent, and corrective of fœtor in otorrhœa and other fetid discharges.*

118. *Lotion of Chloride of Ammonium.*

℞. Ammoniæ hydrochloratis ʒss.; acidi acetici diluti, spiritûs rectificati ää f℥ss.; misturæ camphoræ f℥xv. Misce. *A discutient.*

119. *Nitric Acid Lotion.*

℞. Rosæ petalorum ℈j.; aquæ ferventis f℥viij.; acidi nitrici diluti f℥ijss. Misce, et cola post horam. *To clean foul ulcers.*

120. *Opiate Lotion.*

℞. Pulveris opii ʒss.; aquæ destillatæ ferventis f℥viij.; macera per horas duas, et cola. *For irritable sores, phagedæna, &c.*

121. *Poppy Lotion.*

℞. Extracti papaveris ʒij.; aquæ ferventis f℥iv. Misce. *The addition of a drachm of borax forms a capital lotion for itching eruptions.*

122. *Conium Lotion.*

℞. Extracti conii ʒj.; aquæ destillatæ f℥iij.; tere simul, et macera per horas duas; dein cola. *For painful sores.*

123. *Belladonna Lotion.*

℞. Extracti belladonnæ ℈j.; aquæ f℥iv. Misce, et cola.

124. *Arsenical Lotion.*

℞. Liquoris arsenicalis f℥j.; aquæ destillatæ f℥j. Misce.

125. *Black Wash.*

℞. Calomelanos ʒj.; mucilaginis acaciæ fʒss.; liquoris calcis fʒvss. Misce.

126. *Yellow Wash.*

℞. Hydrargyri sublimati corrosivi gr. vj.—xij.; liquoris calcis fʒvj. Misce.

127. *Chloride of Zinc Lotion.*

℞. Liquoris zinci chloridi (*Sir W. Burnett's*) fʒss.; aquæ destillatæ fʒviij. Misce. *The best lotion for cancer of the womb.*

128. *Iron Lotion.*

℞. Ferri sulphatis gr. viij.; aquæ destillatæ fʒviij. Misce. *See Mr. Vincent's* "Observations," *for the use of this lotion in piles.*

Lotions of the *chloride* of iron may be made by adding two fluid drachms of tincture of steel to four ounces of water; any other preparation will probably do as well. A concentrated solution of *sulphate* of iron was much recommended by Velpeau in erysipelas. The *citrate* of iron, in the proportion of five grains to the ounce is a favourite lotion in phagedænic sores.

129. *Alum Lotion and Bath.*

℞. Aluminis ʒj.; aquæ destillatæ octarium. Misce.

For an *alum bath*, for leucorrhœa, prolapsus uteri, &c., add a tablespoonful of powdered alum to enough cold or tepid water to make a hip-bath; it should be injected by means of an india-rubber syringe (*Higginson's*).

130. *Blue Lotion.*

℞. Cupri sulphatis gr. viij.; aquæ fʒviij. Misce.

131. *Tannin Lotion.*

℞. Tannin ʒss.; spiritûs rectificati fʒj.; aquæ destillatæ fʒiv. Misce.

132. *Oakbark and Catechu Lotions.*

℞. Catechu ʒj.; aquæ ferventis fʒviij. Macera per horam, et cola.

℞. Corticis quercus ʒij.; aquæ ferventis octarium; coque ad consumptionem dimidii, et cola.

133. *Borax Lotion.*

℞. Boracis ʒj.; aquæ destillatæ fʒviij. Misce.

134. *Nitrate of Silver Injection for the Urethra.*

℞. Argenti nitratis (*cryst.*) gr. ij.; aquæ destillatæ fʒviij. Misce. (*Ricord.*)

N.B. Nitrate of silver for solutions ought to be crystallized, and of a pure white colour, not darkened by exposure to light or contact with organic matter.

135. *Sulphate of Zinc Injection.*

℞. Zinci sulphatis gr. viij.; aquæ destillatæ f℥viij. Misce.

136. *Acetate of Zinc Injection.*

℞. Zinci sulphatis, gr. v.; liquoris plumbi diacetatis f℥ss.; aquæ rosæ f℥iv. Misce, fiat injectio.

137. *Acetate of Copper Injection.*

℞. Cupri sulphatis gr. v.; liquoris plumbi diacetatis f℥ss.; aquæ rosæ, f℥iv. Misce, fiat injectio.

138. *Ammoniuret of Copper Injection.*

℞. Liquoris cupri ammonio-sulphatis ♏xx.; tincturæ opii f℥ss.; aquæ rosæ ℥iv. Misce, fiat lotio.

139. *Sulphate of Zinc with Opium.*

℞. Pulveris opii ℈ss.; aquæ ferventis octarium dimidium; macera per horas duas, dein cola et adde zinci sulphatis ℈ss.

140. *Collyria.*

℞. Zinci sulphatis gr. j.; *vel* aluminis gr. j.; *vel* cupri sulphatis gr. ½; *vel* argenti nitratis gr. j.; *vel* zinci acetatis gr. j.; *vel* liq. plumbi diacetatis ♏v.; aquæ destillatæ f℥j. Misce.

One part of good brandy to six of water makes an admirable collyrium for most cases.

141. *Corrosive Sublimate Collyrium.*

℞. Hydrargyri sublimati corrosivi gr. j.; aquæ destillatæ f℥viij. Misce. (*Mackenzie.*)

142. *Opiate Collyrium.*

℞. Zinci sulphatis gr. xij. (*vel* liquoris plumbi diacetatis f℥ss.) liquoris opii sedativi f℥ij.; aquæ destillatæ f℥xij. Misce.

143. *Opodeldoch*, vel *Linimentum Saponis.*

℞. Spiritûs vini rectificati libras iv.; saponis mollis libram unam; digere in leni calore donec fiat solutio, cui adde camphoræ uncias duas, olei rosmarini, origani ää semunciam. Misce, agitando.—*Old Edinburgh Pharm.*

144. *Stimulating Liniments.*

℞. Liquoris ammoniæ f℥ij.; linimenti camphoræ (*vel* linimenti camphoræ compositi) f℥j. Misce, fiat linimentum.

℞. Tincturæ capsici f℥ss.; linimenti saponis f℥ss. Misce.

Dr. A. B. Granville's "*Antidynic*" *Lotion* is composed of strong liquor ammoniæ, spirit of rosemary or eau de Cologne, and spirit of

camphor, in the proportions of about 5, 3, and 1. It is much used as a blister; a round piece of lint the size of a penny being soaked in it, and covered with a round piece of pasteboard. *In neuralgia.*

145. *Pearson's Liniment.*

℞. Olei olivæ f℥jss.; olei terebinthinæ f℥ss.; acidi sulphurici fortissimi f℥jss. Misce gradatim. *A painful irritant.*

146. *Chilblain Liniment.*

℞. Tincturæ cantharidis f℥iij.; linimenti saponis f℥ix. Misce, fiat linimentum. *Wardrop.*

147. *Opiate Liniment.*

℞. Tincturæ opii f℥ss.; linimenti saponis f℥j. Misce.

148. *Conium Liniment, or Epithem.*

℞. Extracti conii ʒj.; glycerine ℥ss. Misce. *In neuralgia and uterine irritation.*

149. *Belladonna Liniment.*

℞. Extracti belladonnæ scrupulum: *glycerine* fluidunciam dimidiam. Misce. *Glycerine is the best vehicle for narcotic liniments, as it penetrates the cuticle, and does not dry, and so renders absorption by the skin more easy.*

The extracts of opium and aconite may be used in like manner.

Anodyne Camphor Liniment.

℞. Camphoræ ʒij.; spiritûs rectificati ʒj.; glycerine ℥j. *A capital soothing rubefacient for chronic rheumatism and neuralgia.*

150. *Mercurial Liniment.*

℞. Unguenti hydrargyri fortioris; adipis ää ℥iv.; camphoræ ℥j.; spiritûs rectificati f℥j.; liquoris ammoniæ f℥iv. Misce.

151. *Croton Oil Embrocation.*

℞. Olei tiglii guttas xxx.; linimenti saponis f℥ss. Misce.

GLYCERINE.

Glycerine was long ago recommended in this work as a vehicle for various medicines as local applications.—Ex gr. F. 148 and 149.

Bismuth and Glycerine Liniment.

℞. Bismuthi trisnitratis in pulverem subtilissimum redacti semiunciam; *glycerine* quantum satis sit fiat linimentum. *This was recommended by the Author many years ago in a case of ulcerated epithelioma of the mouth, which he saw with his friend Mr. Hunt;*

it is soothing and deodorizing. It has since been recommended by an eminent French surgeon.

Glycerine has very many uses in surgery. In the first place it is, *per se*, a capital thing if applied by means of a camel's hair pencil to dry and irritable surfaces; to chafings, excoriations, burns, cracked nipples, itching patches, &c.—external and internal; for example, a dry, chapped tongue, or irritable throat, or irritated rectum or vulva. Secondly, it seems to have penetrating and antiseptic qualities which fit it well as an application to phagedænic and diphtheritic surfaces, hospital gangrene, cancerous and other rebellious ulcers. For diphtheritic sore throat it is admirable.

In the next place, as it dissolves freely water and alcohol, and essential oils (but not fixed oils, fats, and resins), and most saline substances, it is a good adjunct to most lotions, soothing or astringent, in the proportion of one-third or fourth, as a substitute for that proportion of water.

Or the glycerine may be used as the sole vehicle for other ingredients, as in the following formulæ, which are, for the most part, borrowed from M. Demarquay's interesting Treatise "De la Glycerine et ses Applications à la Chirurgie et la Médecine," Paris, Asselin, 1863; an English translation of which has appeared from the pen of Dr. W. Abbotts Smith. It may be remarked that the glycerine should be *pure*; and that Price's is considered the best. The French designate the liquid compound *glycérolés*; and the solid, *glycérats*.

Chloroform Liniment with Glycerine.

℞. *Glycerine* ʒvij.; chloroform ʒj. Misce in mortario. *For lumbago, neuralgia, &c.*

Tannin with Glycerine.

℞. *Glycerine* ʒxv.; tannin ʒiij. Misce. *In vaginitis. If diluted with twice the quantity of glycerine, it may be used as an injection in gleet, and as an application in suppurative conjunctivitis.*

Glycerine may be combined with tincture of iodine, creosote, borax, and almost any other liquid: but there remains the solid *glycerat of starch* which is a capital basis for ointments, and may be substituted for lard or other fat. It is more penetrating, and dries less; and is a convenient medium for calomel, red precipitate, and other mercurial salts. The writer learned its use from Mr. H. Lee.

Glycerat of Starch.

Heat together 6 parts by weight of starch and 30 of glycerine, in a porcelain vessel, over a water-bath, stirring till the starch is completely gelatinized. Another formula is 85 parts of glycerine, 5 of starch, and 10 of water. The result ought to be transparent, gelatinous, and soft.

§ VIII. Poultices.

N.B. Before applying any poultice, it is well to smear the skin with glycerine, in order to hinder particles of bread, linseed, mustard, &c. from sticking.

152. *Bran Poultice.*

Make a linen or flannel bag of the size requisite to cover the part affected, and fill it loosely with bran. Pour boiling water on this till it is thoroughly moistened; put it into a coarse towel, and wring it dry; then apply it so soon as it is cool enough.

153. *Bread Poultice.*

"I shall now speak," says Mr. Abernethy, "of the bread and water poultice. The way in which I direct it to be made is the following:—Put half a pint of hot water into a pint basin: add to this as much of the crumb of bread as the water will cover: then place a plate over the basin and let it remain about ten minutes; stir the bread about in the water, or, if necessary, chop it a little with the edge of the knife, and drain off the water by holding the knife on the top of the basin, but do not press the bread, as is usually done; then take it out lightly, and spread it about one-third of an inch thick on some soft linen, and lay it upon the part."

A very admirable soft poultice for parts that are excoriated, or that threaten to slough from pressure, during long illnesses, may be made by mixing equal parts of bread-crumbs and of mutton suet grated very fine, with a little boiling water, and stirring them in a saucepan over the fire till they are well incorporated.

154. *Linseed Meal Poultice.*

The highest authority on poultices was Mr. Abernethy, who seemed to revel in the idea of them. "Scald your basin," he says, "by pouring a little hot water into it, then put a small quantity of finely-ground linseed meal into the basin, pour a little hot water on it, and stir it round briskly until you have well incorporated them; add a little more meal and a little more water, then stir it again. Do not let any lumps remain in the basin, but stir the poultice well, and do not be sparing of your trouble. If properly made, it is so well worked together, that you might throw it up to the ceiling, and it would come down again without falling in pieces; it is, in fact, like a pancake. What you do next, is to take as much of it out of the basin as you may require, lay it on a piece of soft linen, let it be about a quarter of an inch thick, and so wide that it may cover the whole of the inflamed part."

155. *Yeast Poultice.*

℞. Farinæ lb. j.; cerevisiæ fermenti f℥j. Misce, et calorem lenem adhibe donec intumescant. (Pharm. Lond.)

156. *Mustard Poultice.*

℞. Lini seminum, sinapis, singulorum contritorum libram dimidiam; aceti fervefacti, quantum satis sit; ut fiat cataplasmatis crassitudo. Misce. (Pharm. Lond.)

A far better poultice is made by merely mixing flour of mustard with warm (not boiling) water.

157. *Opiate Poultice.*

℞. Micæ panis, et *lotionis opiatæ* suprapræscriptæ (F. 120), singulorum, quantum satis sit.

158. *Conium Poultice.*

℞. Cataplasmatis panis quantum satis sit; extracti conii ʒj. Misce. These poultices are inferior to F. 147 and 148.

159. *Carrot Poultice.*

Boil carrots till they are quite soft, then smash them into a smooth pulp.

§ IX. Ointments.

N.B. The glycerat of starch, p. 839, or glycerine pure, may be substituted for *adeps* in most of the following ointments with benefit.

160. *Scott's Ointment.*

℞. Unguenti hydrargyri fortioris, cerati saponis āā ʒj.; camphoræ pulverizatæ ʒj. Misce.

161. *Tartar Emetic Ointment.*

℞. Antimonii potassio-tartratis ʒj.; adipis ℥j. Misce.

162. *Ointment for Piles.*

℞. Pulveris gallæ ʒj.; liquoris plumbi diacetatis ♏xv.; adipis ℥j. Misce.

℞. Pulveris opii ℈ss.; liquoris plumbi diacetatis guttas x.; adipis ʒss. Misce.

163. *Creosote Ointment.*

℞. Creosoti guttas viginti; unguenti resinæ, adipis singulorum unciam. Misce.

Peruvian Balsam Ointment.

℞. Balsami Peruviani ʒj.; unguenti cetacei ℥j. Misce.

These, like the old elemi ointment, are good stimulating applications to indolent and sloughing ulcers; but the creosote is a good deodorizer as well. It is good also for piles.

164. *Chalk Ointment.*

℞. Cretæ precipitatæ ℥j.; olei olivæ ʒiij.; adipis ℥ss. Misce. *For burns, excoriations with acrid discharge, &c.*

Bismuth Ointment.

℞. Bismuthi trisnitratis ʒij.; adipis ʒvj. Misce. *A capital ointment for excoriations and irritable sores.*

165. *Magnesia Ointment.*

℞. Magnesiæ carbonatis ʒj.; adipis ℥j. Misce.

166. *Anodyne Bark Ointment.*

R. Extracti *vel* pulveris opii ʒij.; camphoræ ʒj.; pulveris cinchonæ ℥ijss.; adipis *vel* cerati cetacei, ℥v.; spiritûs vini rect. q. s. misce fiat unguentum.—(*Mr. Cole.*)

168. *Veratria Ointment.*

℞. Veratriæ gr. iv.; spiritûs rectificati fʒj.; adipis ʒj. Misce. *In neuralgia. A bit the size of a bean to be rubbed on the painful part.*

163. *Ointments for the Eyelids.**

R. Unguenti citrini (*hydrargyri nitratis*) ʒss.; adipis fʒss. Solve leni calore.†

R. Unguenti citrini ʒss.; hydrargyri nitrico-oxydi in pulverem subtilissimum redacti gr. v.; adipis ʒiv. Misce bene.

R. Liquoris plumbi diacetatis guttas x.; morphiæ acetatis gr. iv.; calomelanos gr. x.; adipis ℥ss. Misce.

169. *Ointment of Nitrate of Silver.*

R. Argenti nitratis gr. iv.; adipis bene loti ʒss. Misce.

170. *Calomel Ointment.*

R. Calomelanos ʒij.; adipis ʒvij. Misce. *In chancre, and condylomata, &c.*

171. *Green, or Verdigris Ointment (Pharm. Ed.)*

R. Cupri acetatis ʒj.; cerati resinæ ℥j. Misce. *For flabby ulcers, warts, indolent eruptions, &c.*

The writer learned the use of this from his friend Dr. R. Dickson.

172. *Goulard's, or Compound Lead Cerate.*

R. Liquoris plumbi diacetatis fʒiij.; ceræ ℥iv.; olei olivæ octarium dimidium; camphoræ ʒss. Melt the wax, and add gradually to it the

* *Singleton's Golden Ointment* for the eyelids is said to be composed of equal parts of orpiment and lard.

† The nitrate of mercury solidifies olive oil, and renders other oils green and rancid, so that it seems better to return to the old formula, and employ lard only, and not oil, in the preparation of the *unguentum citrinum*. Mr. Wilde speaks highly of a *brown* ointment of nitrate of mercury, prepared by the Dublin chemists, some of whom use rape oil, others fish oil.

oil, in which the camphor has been previously dissolved; as they cool, add the liquor plumbi, stirring continually till well mixed.

173. *Red Precipitate Ointment.*

℞. Hydrargyri nitrico-oxydi, optime pulverizati ʒj.; adipis ℥j. Misce.

Chloroform Ointment.

℞. Chloroform 1 part; lard 2; blend quickly by trituration. *Squire.* See, also, chloroform liniment with glycerine, p. 839. *In itching, as pruritus ani, &c.*

§ X. Miscellaneous Prescriptions for various Surgical Diseases.

174. *Demulcent Mixtures for Gonorrhœa.*

℞. Pulveris acaciæ ʒij.; sodæ sesquicarbonatis ʒj.; tincturæ opii ♏xx.; aquæ f℥vijss. Misce. Dosis f℥jss. quater die.

℞. Liquoris potassæ fʒij.; liquoris opii sedativi fʒss.; misturæ amygdalæ f℥vj. Misce. Sumantur cochlearia duo quartâ quâque horâ.

℞. Potassæ bicarbonatis ʒij.; tincturæ hyoscyami fʒij.; tincturæ conii fʒiij.; misturæ acaciæ f℥j.; aquæ f℥vij. Dosis pars sexta ter die.

175. *Copaiba Mixture.*

℞. Copaibæ fʒij.; mucilaginis acaciæ f℥j.; spiritûs ætheris nitrici, spiritûs lavandulæ ãã fʒij.; olei cinnamomi guttas ij.; aquæ f℥v. Misce. Dosis f℥j. ter die.

176. *Copaiba and Oil of Cubebs.*

℞. Copaibæ fʒiij.; olei cubebæ ♏xx.; liquoris potassæ fʒij.; sp. myristicæ fʒiij.; misturæ camphoræ f℥vj.; misturæ acaciæ f℥j. Misce. Sumantur cochlearia duo magna ter die.

Copaiba and Kino.

℞. Copaibæ f℥ss.; pulveris kino ʒj.; mucilaginis acaciæ f℥j.; spiritûs lavandulæ compositi fʒiij.; aquæ f℥v. Misce. Sumantur cochlearia duo magna ter die.

Copaiba and Catechu.

℞. Copaibæ f℥ss.; tincturæ catechu fʒvj.; olei juniperi guttas duas; mucilaginis f℥j.; aquæ f℥v. Misce. Sumantur cochlearia duo ter die.

Turpentine and Copaiba.

℞. Olei terebinthinæ f℥ij.; copaibæ f℥vj. Misce; sumantur guttæ quadraginta ter die, e cyatho aquæ.

177. *Copaiba and Magnesia Pills.*

℞. Copaibæ f℈ss.; magnesiæ carbonatis quantum satis sit ut fiat massa in pilulas dividenda.

178. *Cubebs and Soda.*

℞. Pulveris cubebæ ℈ij.; sodæ sesquicarbonatis; potassæ bitartratis ãã ℈ss. Misce; fiat pulvis, ter die sumendus.

179. *Cantharides and Zinc.*

℞. Zinci sulphatis gr. xxiv.; pulveris cantharidis gr. vj.; pulveris rhei ʒj.; terebinthinæ Venetiensis quantum satis sit, ut fiant pilulæ viginti quatuor, quarum sumantur duæ ter die.

180. *Cantharides and Steel.*

℞. Tincturæ ferri sesquichloridi, tincturæ cantharidis ãã f℥ij.; tincturæ capsici f℥j.; syrupi croci f℥ij.; aquæ pimentæ f℥vj. Misce; sumantur cochlearia duo ter die.

N.B. The combination of quinine with tincture of steel, F. 18, and especially with ♏x. of tincture of nux vomica added to each dose, is a good formula for gleet. Cantharides should be used with much caution.

181. *For Chronic Cystitis.*

℞. Foliorum buchu, et uvæ ursi ãã ʒij.; aquæ ferventis f℥vj. Macera per horas duas; dein cola, et adde liquoris potassæ f℥j.; tincturæ cinnamomi, f℥iij. Misce; sumantur cochlearia duo ter die.

℞. Pareiræ ℥j.; aquæ destillatæ octarium; decoque ad dimidium; dein adde decocti cinchonæ flavæ f℥vj.; tincturæ hyoscyami f℥iij.; sodæ sesquicarbonatis ℈ss. Dosis f℥iij. bis die.

℞. Decocti chimaphilæ f℥j.; syrupi zinziberis f℥j.; spiritûs ætheris nitrici f℥j. Misce, fiat haustus bis die sumendus.

182. *Benzoic Acid.*

℞. Acidi benzoici, ammoniæ sesquicarbonatis ãã ʒj.; syrupi tolutani f℥iij.; aquæ destillatæ f℥vj. Misce. Dosis f℥j. ter die.

℞. Acidi benzoici, extracti papaveris ãã ℈ss. Misce et divide in pilulas xij.; quarum sumantur duæ ter die.

℞. Acidi benzoici, sacchari albi ãã gr. viij. Fiat pulvis, ter die sumendus. *In urinary disorders, chronic bronchitis and cystitis.*

183. *Antiodontalgic Remedies.*

℞. Mastiches ʒj.; spiritûs rectificati (vel *Eau de Cologne*) ℥jss. Solve. *Cotton imbued with this forms a good temporary plug for a carious tooth. The same purpose is answered by a solution of gum copal in æther; or by collodion, or by a solution of gutta percha in chloroform.* See Tomes's Lectures.

Æthereal Tincture of Tannin.

℞. *Tannin* ʒj.; mastiches ʒj.; spiritûs ætheris sulphurici ℥j. Misce.

Camphor with Chloroform.

℞. Camphoræ ʒj.; chloroformi ℥ss.

Tincture of Pellitory.

℞. Radicis pyrethri concisi ℥ss.; spiritûs rectificati ℥iv. Macera per dies xiv., et cola. *Half a teaspoonful mixed with a wine-glassful of water forms a very agreeable wash in nervous and atonic toothache.*

184. *Eye Snuff.*

℞. Pulveris asari partes tres; pulveris florum lavandulæ partes duas. Misce. *Vel* ℞. Pulveris euphorbii partem unam, pulveris amyli partes septem. Misce.

Mercurial Eye Snuff.

℞. Hydrargyri sub-sulphatis flavi ʒss.; pulveris glycyrrhizæ ʒij. Misce intime.

185. *Schmucker's Resolvent Pills.*

℞. Sagapeni, galbani, saponis āā ʒj.; rhei ʒjss.; antimonii potassio-tartratis gr. xv.; succi glycyrrhizæ ʒj. Misce. Dosis, gr. xv. bis die.

Richter's Pills.

℞. Ammoniaci, assafœtidæ, saponis, valerianæ, arnicæ āā ʒij.; antimonii potassio-tartratis gr. xviij.; syrupi quantum satis est ut fiat massa. Dosis, gr. xx.—xxx. ter die. *In amaurosis.*

186. *Gallic Acid Mixture.*

℞. Acidi gallici ℈ij.; syrupi f℥ij.; aquæ destillatæ f℥viij. Misce. Dosis, pars sexta, tertiâ *vel* quartâ quâque horâ. *In passive hæmorrhage.*

187. *Alum Mixtures.*

℞. Aluminis ʒj.; acidi sulphurici diluti f℥jss.; syrupi f℥ss.; infusi rosæ f℥vijss. Misce. Dosis, pars sexta quartâ quâque horâ. *In the same.*

℞. Aluminis ʒj.; lactis Oj.; corticis limonis ℈j.; coque per quartam partem horæ, et cola. *To be drunk cold, ad libitum.*

188. *Resinous Lotion.*

℞. Tincturæ benzoes compositæ ʒj.; aquæ f℥ij. Misce.

189. *Sir A. Cooper's Prescription for Cancer.*

℞. Ammoniæ sesquicarbonatis gr. v.; sodæ sesquicarbonatis ʒss.; tincturæ calumbæ f℥j.; infusi gentianæ compositi f℥jss. Misce, fiat haustus bis die sumendus.

190. *Arnica Montana.*

℞. Foliorum arnicæ ʒij.; aquæ ferventis Oss.; macera per horam, et cola. Dosis ℥j.

℞. Florum arnicæ ℥jss.; spiritûs rectificati Oj.; macera per dies xiv., et cola; vel

℞. Foliorum arnicæ ℥jss.; spiritûs tenuoris Oj.; macera per dies xiv., et cola. Dose ♏xv.—xxx. *In nervous headache, atonic amaurosis, tinnitus aurium, and as a local application for muscular stiffness after bruises.* See *Wilde's Contributions to Aural Surgery, Dublin*, 1848. *Dr. Garrod has shown that the effect of tincture of arnica in causing absorption of a bruise is precisely that of the spirit contained in it, and no more.*

191. *Phosphorus Pills.*

℞. Micæ panis ʒj.; aquæ destillatæ quantum satis sit ut fiat massa idoneæ crassitudinis, dein adde phosphori granum unum. Misceantur bene et divide in pilulas xx. Dosis, una ter vel quater die. *In intense nervous debility. Of doubtful efficacy.*

192. *For Ulceration of the bowels, after fever, in Phthisis, &c.*

℞. Cupri sulphatis gr. iij.; pulveris opii gr. jss.; extracti glycyrrhizæ q. s., ut fiat massa in pilulas vj. dividenda. Sumat unam quartis horis.

193. *To melt Nitrate of Silver for the purpose of coating a Probe, or Sound.*

"Some powdered lunar caustic, from six to twenty grains, is to be moistened with water in a little porphyry dish, boiled up over a spirit lamp, and constantly stirred with a silver knife till the water have evaporated, and the caustic remain fluid in its water of crystallization alone, which may be ascertained by its thin pap-like appearance, and the formation of the crystallization-film. This paste is now to be spread with the spatula on the slightly-heated groove of the caustic-holder, and, when it has cooled, any projection is to be removed with the spatula, or with pumice-stone. Whilst boiling, the caustic flies about smartly, and therefore it is necessary to put on a glove, so that the hand be not spotted with black."—*South's Chelius.*

194. *To make common Bougies.*

"A piece of fine linen, which has been already used, nine inches long and half an inch to an inch in width, according to the thickness of the bougie to be made, is to be dipped into melted plaster, and when a little cooled, spread flat and even with a spatula; it is then to be rolled together between the fingers, and afterwards between two plates of marble till it is quite firm and smooth. The bougie must be equally thick throughout its whole length to about one inch from its point, from whence it should gradually taper, and terminate in a firm round point. Bougies are also made by dipping cotton-threads in melted wax till they have acquired sufficient size, after which they are rolled between marble plates."—*South's Chelius. This formula may be useful to surgeons on foreign stations.*

195. *Acid Nitrate of Mercury.*

Dissolve one part of mercury in two parts of strong nitric acid, and evaporate to three-fourths.—*Paris Codex.*

196. *Essence of Beef.*

Take a pound of lean beef, free from skin, bone, and fat: chop it up; put it into a large earthen jar with cover; cement the edges with flour paste; tie it up tightly in a cloth; plunge it into a saucepan, and let it boil for two hours; pour off the liquid essence from the coagulated muscle; let it stand till cold; skim off the fat.

This essence is prepared for sale by Messrs. Brand of 11 Little Stanhope Street. See a communication by the author to the Obstetrical Society, Obst. Trans., vol. iii., p. 143, and a letter in the Medical Times and Gazette for 1861, vol i., pp. 536, 587, advocating the use of this essence as a substitute for brandy in cases of *debility and nervous exhaustion.* The writer must also mention in terms of high commendation, Gillon's Essence of Beef, Mutton, Chicken, &c., preserved in tins, and sold wholesale in London by J. Bell and Co., Oxford Street.

Purée of Meat.

Take any raw or underdone meat, chicken, or mutton by preference; cut off skin and fat, pound it in a mortar until it is a paste if raw, or a powder if cooked. Diffuse a tablespoonful of this through half a pint of good beef soup.

Meat Custard.

Take any cooked meat, pound it to a powder; separate sinew, fibre, &c.; mix it with yolk of egg and milk, to make a custard: flavour with salt and a little marjoram; gently cook it till it sets. *These are means of administering meat to patients too feeble to masticate.*

197. *Nitrate and Muriate of Ammonia.*

℞. Ammoniæ muriatis ʒij.; aquæ destillate fʒviij. Misce. Sumat partem sextam vel quartam ter die.

℞. Ammoniæ nitratis ʒss.; aquæ fʒvss.; syrupi aurantii fʒjr. Misce. Sumat cochlearia duo ampla ter die. *Dr. Egan. In rheumatism and secondary syphilis.*

198. *Solution of Sulphate of Atropia.*

℞. Atropiæ sulphatis gr. ss.; aquæ destillatæ fʒj. Misce, fiat solutio. Except in cases of cataract, Mr. Walton uses a weak solution like this. A stronger solution acts more quickly; but the dilatation remains too long; and patients complain that the adjusting power of the sound eye is interfered with.

199. *To make a Metallic Amalgam or Cement, to fill Decayed Teeth.*

Rub together in a mortar some silver, reduced to a fine powder by filing or by precipitation, with a few globules of mercury. When well mixed into a paste, knead it well with the fingers, and squeeze out any superfluous mercury. Then the cavity of the tooth having been properly scraped out and dried, fill it with the amalgam, making the surface of the metal smooth and even with that of the tooth. The patient must be desired not to use the teeth for some hours, till the amalgam has become hard.

200. *Pills of Chian Turpentine.*

This substance may be made into pills each five grains in weight; which may be sent out in a phial of water, to prevent them from sticking together.—(*C. R. Walsh.*) *In cystirrhœa, &c.*

201. *Phosphate of Lime.*

This may be prepared by boiling about four ounces of ivory dust in water for ten minutes. This water should be strained off and thrown away, to get rid of impurities. Then more water should be added, in which the dust should be stewed, till the jelly is extracted, and itself is soft enough to crunch between the teeth. Lemon-juice, wine, sugar, or other flavouring ingredients may be added; and the softened ivory dust be eaten with the jelly.

Or, any quantity of ivory dust or bones may be calcined white, and diluted hydrochloric acid be saturated with it. The dissolved earth should be precipitated by ammonia, and washed; and dilute hydrochloric acid be again saturated with it. This dose is from ten to thirty minims, in sugared water. This is prepared under the writer's directions by Mr. Jolley, of Curzon Street, and Mr. Bullock, of Hanover Street, Hanover Square.

Mr. Bullock tells the writer that he has known a patient take two fluid ounces daily of the dilute muriatic acid of the P. L. containing half an ounce of bone phosphate in solution.

202. *The Eye Douche.*

The application of a continuous stream of cold or tepid water to the eyelids and adjacent parts is a favourite remedy with most oculists in cases of chronic, congestive, or weak diseases of that organ. There are many contrivances which may serve this purpose, such as the elastic syringe which we have recommended in diseases of the ear; tubes of gutta percha or vulcanized caoutchouc, leading from a small cistern placed at the proper height, and the eye douches of Savory and Moore, Matthews, &c.

203. *Disinfectants.*

These are of three sorts: 1. Substances that hinder decomposition and preserve any given compound *in statu quo*; 2. Substances that hasten or complete oxydation, and reduce the decomposing body to a harmless state; 3. Such as absorb or neutralize gaseous emanations. Each has its uses. To the first class belong creosote, carbolic acid; half a drachm of either of which, with an ounce of glycerat of starch, will make a good ointment for a gangrenous wound; also F. 117, 127. To the second class belong Condy's excellent Disinfecting Fluid, the permanganate of potass, and the chloride of lime, and of soda; which last is much less unpleasant than the chloride of lime. Also solution of chlorine (liquor chlori of the P. B.). Under the third head come bags of charcoal, lotions of nitrate of lead, F. 116, glycerate of bismuth, p. 838, together with fumigation of chlorine, nitrous acid, and of iodine. *Iodine* is the cheapest and most generally useful. A few grains may be put into pill boxes with perforated lids, which should be placed in different parts of the ward, as recommended by Dr. B. W. Richardson; or a cheap tincture of ½ oz. iodine to Oss. of methylated spirit may be used. Fumigations also of vinegar, pastiles, cascarilla bark, &c., have their uses, as they evolve tarry matters, which purify the air. A very pure carbolic acid is made by Mr. Rew, chemist, of 282, Regent Street.

204. *Chlorate of Potass.*

This salt has been recommended on the ground of its containing six equivalents of oxygen, which it was supposed to part with in the blood and be converted into chloride. This hypothesis is quite unproved and very improbable; still the fact remains, as first propounded by Mr. Hunt, that it forms a useful local and general remedy in cachectic ulcers of the mouth and throat. It may be used as a lotion in the proportion of one drachm to an ounce of glycerine and three ounces of water. It may also be made into lozenges or tablets (*Parrish*). As an internal remedy the dose is 10 to 30 grains in solution. Or a mixture may be made of two drachms chlorate of potass, half a drachm dilute hydrochloric acid, three of syrup, and six ounces of water. Dose, a sixth part every four hours. *In low putrid sore throat, and analogous diseases.*

205. *Combinations of Mercury with Tonics.*

℞. Pilulæ hydrargyri ℈ij.; ferri sulphatis exsiccati ℈j.; extracti opii gr. v. Misce; and divide in pilulas xx.; quarum sumantur duæ hora somni et una mane.—*Bumstead.*

℞. Hydrargyri cum cretâ ℈ij.; quinæ disulphatis ℈j.; mannæ quantum satis est ut fiat massa in pilulas xx. dividenda.—*Ibid.*

Corrosive Sublimate with Cod Liver Oil.

℞. Hydrargyri corrosivi sublimati granum; ætheris sulphurici ʒss.; solve, and adde olei Jecoris Aselli fʒiij.

Dosis, ʒij., ter die. *Ibid. The bottle must be kept closely corked.*

206. *Ether and Camphor for Inhalation.*

℞. Camphoræ ʒj.; ætheris ℥ss.; Misce. *A few drops to be inhaled from a handkerchief in violent nervous headache, neuralgia, colic, uterine spasms during pregnancy, dysmenorrhœa, &c.*

207. *Other Antisyphilitic, Antistrumous, and Absorbefacient Remedies.*

Certain remedies which seem to have the power of causing atrophy of morbid cell-growth, are of use alike in chronic inflammation, thickening, chronic rheumatism, some ulcers, scrofula, and some tumours, especially of bone and fibrous tissue. They are, 1st, *mercury*, F. 63, 66, 87, &c.; 2, liquor potassæ; 3, certain salts of *potash* and *soda*, as the chlorate; 4, certain salts of *ammonia*, as the carbonate, chloride, and nitrate (see pp. 41, 42, and F. 197); 5, compounds of *iodine*, F. 94, &c.; 6, the analogous compounds of *bromine*; 7, certain other metals, as *gold* and *platinum*. The writer advises that in obstinate syphilis, in nervous diseases, epilepsy, &c. (see p. 214), tumours, &c., these remedies be given perseveringly in alternation or conjunction, with some nutrient or tonic. Thus, $\frac{1}{24}$ of a grain of the *chloride of gold and sodium*, in a pill (with a glass of sarsaparilla) thrice daily;—or a drachm of iodide of potassium, half a drachm of bromide, and half a drachm of chloride of ammonium, to a wine-bottle of distilled water, which the patient should take in a week in divided doses. *Seaweed* and its ashes should be used; and *laver* be eaten as a vegetable at table.

208. *Lithia.*

This is a good remedy for gouty persons, to carry off lithic acid in solution. The best form is Savory and Moore's "granulating effervescing carbonate," in bottles at one shilling per ounce, combined with other ingredients that make a palatable effervescing drink at meals.

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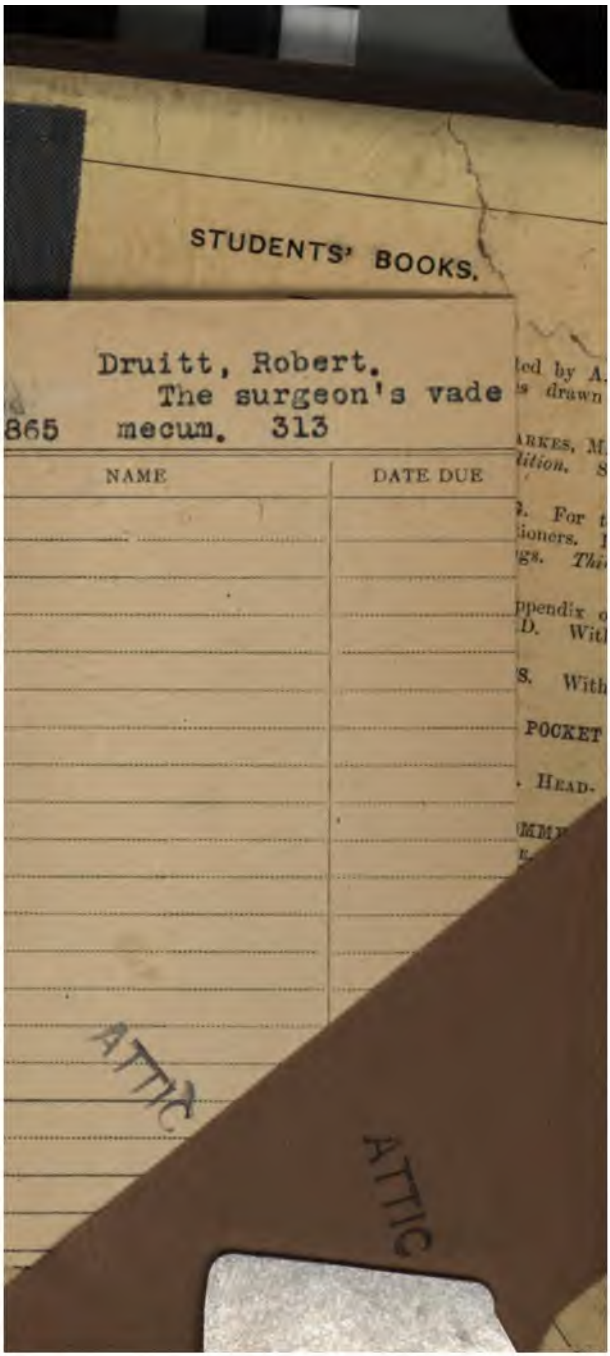
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